The Senate

Foreign Affairs, Defence and Trade References Committee

The Constant Battle: Suicide by Veterans

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ASSISTANCE CONTACT INFORMATION

Veterans and Veterans Families Counselling Service
1800 011 046
www.vvcs.gov.au

Lifeline
13 11 14 (24 hour crisis hotline)
www.lifeline.org.au

Mensline Australia
1300 78 99 78
www.mensline.org.au

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Abbreviations

AAT	Administrative Appeals Tribunal
ABS	Australian Bureau of Statistics
ADF	Australian Defence Force
ADSO	Alliance of Defence Service Organisations
AISRP	Australian Institute for Suicide Research and Prevention
ANAO	Australian National Audit Office
APS	Australian Public Service
APSC	Australian Public Service Commission
AWM	Australian War Memorial
Baume report	*A Fair Go: Report on Compensation for Veterans and War Widows*
BEST	Building Excellence in Support and Training
CDDA	Compensation for Detriment Caused by Defective Administration
CDF	Chief of the Defence Force
CFT	continuous full time
Clarke review	*Review of Veterans' Entitlements*
CSC	Commonwealth Superannuation Corporation
CTSS	Centre for Traumatic Stress Studies
Defence	Department of Defence
DFWA (Qld)	Defence Force Welfare Association (Queensland Branch)
DRCA Bill	Safety, Rehabilitation and Compensation Legislation Amendment (Defence Force) Bill 2016
DRCA	Safety, Rehabilitation and Compensation (Defence-related Claims) Act 1988 (proposed legislation created by DRCA bill)
Dunt Review	*Review of Mental Health Care in the ADF and Transition through Discharge*
Dunt study	*Independent study into suicide in the ex-service community*

DVA	Department of Veterans' Affairs
ESO	Ex-Service Organisation
GARP	Guide to the Assessment of Rates of Veterans' Pensions
Gold Card	DVA Health Card – for All Conditions
GP	General Practitioner
MHPW study	2010 ADF Mental Health Prevalence and Wellbeing Study
MO	Medical Officer
MOU	Memorandum of Understanding
MRCA	*Military Rehabilitation and Compensation Act 2004*
MRCA review	*Review of Military Compensation Arrangements*
MRCC	Military Rehabilitation and Compensation Commission
NMHC	National Mental Health Commission
NMHC report	*Review into the Suicide and Self-Harm Prevention Services Available to current and former serving ADF members and their families*
PTSD	Post-traumatic stress disorder
Tanzer Review	*Review of the Military Compensation Scheme*
RMA	Repatriation Medical Authority
RSL	Returned and Services League of Australia
SoPs	Statements of Principles
SRCA	*Safety, Rehabilitation and Compensation Act 1988*
VEA	*Veterans Entitlements Act 1986*
VRB	Veterans Review Board
VVFA	Vietnam Veterans' Federation of Australia
VVCS	Veterans and Veterans Families Counselling Service
White Card	DVA Health Card – for Specific Conditions

Recommendations

Recommendation 1

3.97 The committee recommends, that in the context of recent Australian Institute of Health and Welfare findings concerning veterans at risk of suicide, the Australian Government:

- **develop and implement specific suicide prevention programs targeted at those veterans identified in at-risk groups; and**
- **expand the DVA Reconnects Project to proactively contact veterans in these identified in at-risk groups.**

Recommendation 2

3.99 The committee recommends that the Australian Government commission an independent study into the mental health impacts of compensation claim assessment processes on veterans engaging with the Department of Veterans' Affairs and the Commonwealth Superannuation Corporation. The results of this research should be utilised to improve compensation claim processes.

Recommendation 3

3.102 The committee recommends that the Australian Government establish a National Veteran Suicide Register to be maintained by the Australian Institute of Health and Welfare.

Recommendation 4

3.104 The committee recommends that the Australian Government review the enhancement of veteran-specific online training programs intended for mental health professionals. In particular:

- **requirements for providers to undertake training;**
- **the introduction of incentives for undertaking online training and demonstrating outcomes in clinical practice.**

Recommendation 5

3.106 The committee recommends that Defence and the Department of Veterans' Affairs align arrangements for the provision of professional mental health care.

Recommendation 6

4.85 The committee recommends that the Australian Government make a reference to the Productivity Commission to simplify the legislative framework of compensation and rehabilitation for service members and veterans. In particular, this review should examine the utilisation of Statements of Principle in the determination of compensation claims. The report of this systemic review should be completed within 18 months and tabled in the Parliament.

Recommendation 7

5.99 The committee recommends that the Australian Government continue to support the 'Veteran Centric Reform' program within the Department of Veterans' Affairs.

Recommendation 8

5.101 The committee recommends that, while the Veteran Centric Reform program is being implemented, the Australian Government continue to fund measures to:

- **alleviate pressure on claims processing staff and to reduce the backlog of claims; and**
- **increase case coordination staff to assist clients with complex needs.**

Recommendation 9

5.103 The committee recommends that the Department of Veterans' Affairs conduct a review of its training program to ensure relevant staff:

- **have an understanding of the realities of military service;**
- **have an understanding of health issues of veterans;**
- **have appropriate communication skills to engage with clients with mental health conditions; and**
- **have sufficient training to interpret medical assessment and reports.**

Recommendation 10

5.105 The committee recommends that the Department of Veterans' Affairs review its use of medico-legal firms in relation to the assessment of the conditions of veterans. In particular, this review should confirm:

- **assessments undertaken are appropriate to the conditions considered;**
- **that the medical professionals used have undertaken training on treating veterans and can demonstrate their expertise working amongst this client group; and**
- **the need for independent medical assessments where information is already available from the veteran's own doctor or treating specialist.**

Recommendation 11

5.107 The committee recommends the Department of Veterans' Affairs expand its online engagement with younger veterans through social media to raise awareness regarding available support services.

Recommendation 12

5.113 The committee recommends that the reference to the Productivity Commission should also include examination of the following areas in the Veterans' Affairs portfolio:

- **governance arrangements;**

- **administrative processes; and**
- **service delivery.**

Recommendation 13

5.115 The committee recommends that the Australian National Audit Office commence the proposed performance audit of the 'Efficiency of veterans' service delivery by the Department of Veterans' Affairs' as soon as possible.

Recommendation 14

6.95 The committee recommends that Transition Taskforce examine and address:

- **any gaps in medical services or income support for veterans in transition or immediately following transition;**
- **barriers to employment for veterans who are transitioning such as workers' insurance issues and civilian recognition of qualifications, skills and training; and**
- **disincentives for veterans to undertake work or study resulting from the legislative or policy frameworks of the Department of Veterans' Affairs.**

Recommendation 15

6.99 The committee recommends that the Department of Veterans' Affairs develop a two-track transition program for serving members leaving the ADF. Those identified as being in 'at risk' groups or requiring additional assistance due to their circumstances should be able to access intensive transition services. These intensive transition services should include additional support:

- **claims case management;**
- **healthcare, mental health and wellbeing support;**
- **employment assistance programs;**
- **social connectedness programs; and**
- **health and wellbeing programs.**

Recommendation 16

6.102 The committee recommends the Australian Government issue all ADF members transitioning into civilian life with a DVA White Card.

Recommendation 17

6.104 The committee recommends that the Career Transition Assistance Scheme include an option for veterans to undertake a period of work experience with an outside employer.

Recommendation 18

6.106 The committee recommends that the Australian Public Service Commission conduct a review into mechanisms to further support veteran employment in the Australian Public Service and the public sector.

Recommendation 19

6.109 The committee recommends that the Department of Veterans' Affairs review the support for partners of veterans to identify further avenues for assistance. This review should include services such as information and advice, counselling, peer support and options for family respite care to support partners of veterans.

Recommendation 20

7.73 The committee recommends:

- **the Australian Government expand the Veterans and Community Grants program to support the provision of alternative therapies to veterans with mental health conditions; and**
- **the Department of Veterans' Affairs consult with ex-service organisations and the veteran community regarding avenues to reform the Veterans and Community Grants program to support the provision of alternative therapies to veterans.**

Recommendation 21

7.75 The committee recommends the Australian Government fund a trial program that would provide assistance animals for veterans with Post Traumatic Stress Disorder (PTSD) stemming from their military service in order to gather research to support the eventual funding of animals for veterans with PTSD and/or other mental health conditions through the Department of Veterans' Affairs.

Recommendation 22

7.79 The committee recommends that the Australian Government provide funding to support the Veterans and Veterans Families Counselling Service:

- **create and maintain a public database of services available to veterans; and**
- **provide an information service to assist veterans and families connect and access appropriate services provided by ex-service organisations and others.**

Recommendation 23

7.84 The committee recommends that the Australian Government establish a Bureau of Veterans' Advocates to represent veterans, commission legal representation where required, train advocates for veterans and be responsible for advocate insurance issues.

Recommendation 24

7.87 The committee recommends that the Australian Government establish an independent review of the representation of veterans before the Veterans' Review Board. This review should assess whether the rights of vulnerable veterans are being adequately protected and whether further support mechanisms for veterans appearing before the Veterans' Review Board are required.

Chair's foreword

Lest We Forget. But let us remember and meet our obligations.

- The Hon Jeff Kennett AC, 11 November 2016

At the inquiry's public hearing in Perth, a witness underlined the importance of the primary topic of the inquiry. He noted that the dead cannot speak for themselves, but he felt the presence of those veterans lost to suicide in the room observing the proceedings. Members of the committee also feel the burden of that responsibility. At the outset, the committee wishes to acknowledge the service of those current and former members of the Australian Defence Force who have taken their own lives and the sorrow of their families and loved ones. In particular, the committee extends its deepest condolences to those families who lost serving or ex-serving members to suicide during the course of the inquiry.

The committee has chosen to title its report *The Constant Battle* which reflects the problematic nature of the issue of suicide by veterans and ex-service personnel. For modern veterans, it is likely that suicide and self-harm will cause more deaths and injuries for their contemporaries than overseas operational service. Some affected veterans characterised their post-service life as being the most difficult and challenging period of their lives. The effort to prevent suicide by veterans is a series of hidden personal conflicts, cloaked by stigma, unreliable information and the inherent reluctance of members of the defence community to request assistance. Unfortunately, the effort to address suicide in the veteran community is likely to be a struggle that has no end-point.

However, it is also important to recognise that the majority of ADF members will leave their service enriched by the experience and will go on to be successful in their civilian endeavours. The members of ADF receive some of the best training in the world and leave service with valuable skills and experience that can be transferred to benefit the Australian society in a broad field of endeavours. Veterans are an essential part of the fabric of our society. The inquiry has highlighted the number of persons with military experience contributing in politics, business, health services, public service, charities and civil society.

Not all the examples provided to the committee have been negatives ones. There have been many instances of veterans pulled back from the brink by partners, friends, advocates and health professionals. DVA clients have expressed their gratitude with the assistance they have received from DVA and other agencies. Other veterans have charted their own paths to recovery and have gone on to support and guide others. In Brisbane, the committee was pleased to meet one of the groups arranging for veterans with PTSD and other conditions to receive assistance dogs. It was clear this had become an invaluable part of their lives and they were passionate about making this assistance available to other veterans in similar circumstances.

A unique aspect of this inquiry has been examining the framework of military compensation arrangements and their administration through the lens of the issue of suicide by veterans. This focus has highlighted the burden of legislative complexity

and administrative hurdles on veterans who are often seeking support at a vulnerable period of their lives. The committee's inquiry has been conducted in a dynamic policy environment where there have been major developments in relation to several issues including suicide by veterans, the legislative framework in the Veterans' Affairs portfolio and the administration of claims by DVA as well as several other related issues. Community alarm and media attention regarding the number of veteran deaths by suicide has continued to increase. The broad scope of the terms of reference and their interrelated nature has been challenging. An extremely wide range of relevant matters were raised with the committee, particularly in relation to the reasons why Australian veterans are taking their own lives. The committee has been forced to focus its consideration on a limited number of key issues.

Every death by suicide is tragic loss with impacts for family, friends, colleagues and broader community. The committee agrees with the position put by some during the inquiry that the aspirational target rate for suicide by veterans and ex-service personnel should be zero. However, it would be misleading to represent that the recommendations in this report will achieve that goal. Any effective measures to decrease the rate of suicide by veterans and ex-service personnel will require a long-term multifaceted approach involving government, business, non-government and ex-service organisations and the wider Australian community. Change is likely take a substantial period of time.

The incidence of suicide by veterans will continue to be an issue demanding attention. While there is no easy solution, this does not mean that improvements are impossible and should not be attempted. The committee has made a series of recommendations. If adopted, some of these recommendations may involve substantial change. Nonetheless, the impression of the committee is there an appetite for reform in the support provided for veterans. Throughout the inquiry, an overwhelming public concern for the welfare of veterans has been evident. Translating that goodwill into effective measures to assist veterans who need support will be the continuing challenge.

While it was not a focus during the inquiry, the committee wishes to note its support for the proposed memorial on the grounds of the Australian War Memorial (AWM) as a dedicated place of remembrance for those who served and took their own lives.[1] While there are likely to be a range of opinions about this proposal, in the view of the committee a memorial could serve as an important marker to indicate progress in community awareness regarding suicide by veterans, an acknowledgement of the service of those lost and a commemorative area for bereaved families. The committee commends the sensitive and consultative approach that the AWM has indicated it will adopt in relation to this proposal.[2]

The committee has received evidence from current and former service members who have frankly described their own mental health challenges, suicidal ideation, self-harm

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1 RSL, 'RSL National and the Australian War Memorial Partner in Veteran Suicide Memorial', *Media Release*, 1 May 2017.

2 Dr Brendan Nelson, *Committee Hansard*, Budget Estimates, 30 May 2017, p. 91.

and suicide attempts. Bereaved widows, partners, parents, friends and advocates have shared stories which have often ended in tragic loss. In some cases, submitters provided the committee with information which they have not even disclosed to close family members. Some of these personal stories have been hard to read. It is difficult to imagine the trauma of living through the experiences described. However, this evidence has played an important role in assisting the committee's understanding of the topics in the terms of reference. As Chair, I wish to record the committee's gratitude to all those who contributed to the inquiry.

Executive Summary

This was a very large and complex inquiry with terms of reference which could easily have taken multiple reports to cover. Rather than produce a number of reports, the committee has sought to table this report as soon as possible. The clear message to the committee was that immediate as well as longer term action is required to address suicide by veterans.

The committee appreciates that not everyone has the time to read this report cover to cover and provides this executive summary to give an overview of the key issues from the evidence and highlight key recommendations. Recommendations are categorised into short, medium and long term.

Short term

Streamlining administration

The need to streamline the administrative practices of DVA was the overwhelming concern of the majority of submissions to the inquiry. The importance of improvements in this area is also recognised in the committee's longer term recommendations. Recent improvements through DVA's 'Veteran Centric Reform' program have highlighted the potential for further reform of administrative processes which can be rapidly achieved. **The committee has recommended that the government continue to support and fund the 'Veteran Centric Reform' program in DVA** (see Chapter 5).

At the same time as pursuing the 'Veteran Centric Reform' program, the committee has **recommended the government continue to fund measures to reduce the backlog of claims and increase case coordination staff to assist clients with complex needs.** To facilitate further assessment and improvement of administrative practices, **the committee has recommended that the Australian National Audit Office commence a performance audit of the 'Efficiency of veterans' service delivery by the Department of Veterans' Affairs' as soon as possible** (see Chapter 5).

Staff training

The committee was concerned to hear that some clients felt they had not been treated with respect by DVA officers. The committee acknowledges the difficulties of interacting with clients who are very frustrated with the processes and may be experiencing mental health issues. The committee would therefore like to ensure that relevant DVA staff interacting with clients have appropriate and up-to-date training. **To this end the committee has recommended that DVA review its training to ensure that staff have an understanding of: military service; the health issues of veterans; have appropriate skills to deal with mental health conditions; and training regarding interpreting medical assessment reports** (see Chapter 5).

Improving engagement

The committee appreciates the diverse nature of the veteran community and that it provides a challenge for DVA to ensure appropriate engagement. Older veterans are

generally not reliant on online resources but contemporary veterans expect them. The committee believes there is scope for DVA to enhance its digital communication through social media to reach younger veterans. This would assist with referring clients to the most appropriate resources. **The committee has recommended DVA expand its online engagement through social media** (see Chapter 5)**.**

Targeted programs based on new research

The committee commends recent research in this area, such as the AIHW findings concerning veterans at-risk of suicide, and believes more can be done to respond to new research findings. The committee considers better use of this research identifying 'at-risk' cohorts in the ADF and veteran community to target proactive support programs is needed. Research findings such as those by the AIHW should be used to develop new targeted suicide prevention and veteran support programs. **The committee has recommended that the government develop and implement targeted suicide prevention programs based on the new research. The committee also recommended that the government expand the DVA Reconnects project to proactively contact veterans in at-risk groups** (see Chapter 3).

Increasing access to the mental health community

The committee heard about a lack of experience in treating veteran specific issues within the wider mental health community. The committee considers that enhancements to online resources and training programs could assist with this issue. **The committee has recommended that the government enhance the provision of veteran-specific online training programs** (See Chapter 3)**.** Further, mental health professionals highlighted discrepancies between the fees paid by Defence and DVA as a barrier to veterans accessing support. **The committee has recommended that Defence and DVA align their arrangements for the provision of professional mental health care** (see Chapter 3)**.**

Addressing issues in transition

Appropriate support is essential to assist ADF members transition to civilian life. Significant reform in this area is occurring. **The committee has recommended the Transition Taskforce examine and address gaps in support to veterans, barriers to employment and any disincentives for veterans undertaking work and study.** Vulnerable ADF personnel can fall through the cracks of support in the transition process. **The committee has recommended a two-track transition process be established with intensive support for veterans who will need it. Furthermore, the committee has recommended all transitioning ADF members should be provided with a DVA White Card to facilitate access to non-liability health care, serve as veteran identification and as a platform for data collection** (see Chapter 6)**.**

Accessing the benefits of alternative therapies

The committee heard from veterans with mental health conditions who felt alternative therapies had significantly improve their conditions. The committee accepts that the evidence base is developing in relation to many alternative therapies but several are being provided through ESOs and other groups. The committee believes there is scope to expand the reshape the existing programs to take account of the benefits of these

therapies. **The committee has recommended that the government expand the Veterans and Community Grants program to support the provision of alternative therapies to veterans with mental health conditions**. **The committee also recommended that DVA consult ex-service organisations and the veteran community about ways to reform the Veterans and Community Grants program to support the provision of alternative therapies**.

In particular, the committee perceived value in developing an evidence base in Australia for supporting the use of complementary treatments, such as the effectiveness of companion and assistance animals. **The committee has recommended funding for a trial program that would provide assistance animals for veterans with Post Traumatic Stress Disorder (PTSD) stemming from their military service in order to gather research** (see Chapter 7).

Medium term

National suicide register

A clear message from the evidence was the wish for an on-going register of veteran suicide. The committee agrees that there should be a national register. **The committee has recommended that the government establish a national veteran suicide register to be maintained by the Australian Institute of Health and Welfare** (see Chapter 3).

Research

The committee was very concerned by accounts of negative interactions with DVA. It is logical that veterans who were satisfied with their experiences were less likely to be interested in the inquiry. Nonetheless, the committee believes a key contention by many witnesses, that the claims process is a key stressor and contributing factor to suicide by some veterans should be looked at closely. **The committee has recommended that the government commission an independent study into the mental health impacts of the claims processes**. Results from this study would feed into medium and longer term recommendations to address administrative issues described below (see Chapter 3).

Medical assessment

Many veterans told the committee that they were unhappy with their experiences in medico-legal firms and being required to attend multiple appointments. The committee supports efforts by DVA, Defence and CSC to implement a single medical assessment process. However the committee **has recommended that DVA reassess its use of medico-legal firms to ensure the assessments are appropriate for conditions of veterans, particularly mental health conditions** (see Chapter 5).

Further supporting veteran employment

Gaining meaningful employment one of the most important components of success for veterans in their post service lives. However, those transitioning from the ADF can struggle to connect with employers and employers can be unsure about transferrable skills. **The committee has recommended the Career Transition Assistance Scheme include an option for veterans to undertake a period of work experience with an outside employer.** The valued skills and experience of ADF members means

they are often well suited to other public sector careers. **The committee has recommended that the Australian Public Service Commission conduct a review into mechanisms to further support veteran employment in the Australian Public Service and the public sector** (see Chapter 6).

Support for partners

A supportive and inclusive approach to the families of veterans in the transition process is vital to ensuring the long-term well-being of veterans. However, a consistent theme from the evidence received was that there was a lack of support for the partners of veterans who have mental health conditions or have acquired severe disabilities arising from their service. **The committee has recommended that the Department of Veterans' Affairs review the support for partners of veterans to identify further avenues to support.** This review should include services such as information and advice, counselling, peer support and options for family respite care to support partners (see Chapter 6).

Navigating support

There are a complex range of services available for veterans and the committee heard that people struggle to navigate them. The committee was attracted to the idea of a single point of information that can operate to link veterans with local services and support. The committee believes that the Veterans and Veterans Families Counselling Service is the most appropriate organisation to take on this role as it is trusted in the defence community and received praise for the services it offers. **The committee recommended that the government provide funding to support the Veterans and Veterans Families Counselling Service to create and maintain a public database of services available to veterans and to provide an information service to assist veterans and families connect appropriate services** (see Chapter 7).

Veteran's Review Board

The committee was concerned that the practice of preventing veterans bringing their lawyer to the VRB is appropriate in all cases. A number of examples were provided where vulnerable veterans felt underrepresented or were unable to fairly engage with VRB proceedings. The committee accepts that this practice has been maintained in order to allow the VRB to be an open and non-adversarial forum for veterans to seek review of decisions. The committee also acknowledges the genuine efforts that the VRB makes to support veterans in its proceedings.

However, given the long-term future of veterans is in the balance, and the structural barriers involved in making an appeal to the AAT, veterans should be able to achieve the fairest hearing possible. **The committee has recommended an independent review of the representation of veterans before the VRB** (see Chapter 7). This review should assess whether the rights of vulnerable veterans are being adequately protected and whether further support mechanisms for veterans appearing before the Veterans' Review Board are required.

Longer term

Addressing legal and administrative complexity

The burden of legislative complexity and administrative hurdles impacts veterans when they are seeking support at a vulnerable period in their lives. The complexity of the legislative framework was a key theme from the evidence received. While arguably the most important issue during the inquiry, the committee recognises there is no quick fix.

Some previous reviews have examined at this issue but ultimately recommended that a single piece of legislation not be pursued. This assumption that a single piece of legislation cannot easily be achieved, has resulted in ad hoc measures intended to simplify the system. While any simplification is welcome, the fundamental complexity in the system has remained.

The committee agrees with witnesses that the current framework is complex and confusing and contributes to the frustration felt by veterans and ex-service personnel in dealing with DVA. There are two aspects: the legal complexity which has resulted in administrative complexity.

Other jurisdictions have simpler legislative frameworks for veterans. While the committee acknowledges steps being taken by DVA to streamline some aspects of their processes the committee anticipates that simplifying the legislative framework would result in efficiencies for all, including flowing through to the time taken to process claims. **The committee has recommended that the government ask the Productivity Commission to review the legislative framework and administrative processes with the objective of simplifying the system. In particular, this review should examine the utilisation of Statements of Principle in the determination of compensation claims. The review should be completed within 18 months and be tabled in the Parliament** (see Chapters 4 and 5)

The committee recognises the ICT issues with multiple systems adding to the complexity and the lack of investment in efficient ICT. The committee reaffirmed its recommendation from the inquiry into the mental health of ADF serving personnel[1] that DVA be adequately funded to achieve full digitisation of its records and modernisation of its systems by 2020, including the introduction of a single coherent system to process and manage claims.

Advocacy

The committee commends the excellent work of advocates in assisting veterans make claims. Volunteer and ESO supported advocates will continue to be required to assist the vast majority of veterans to make claims. However, the decreasing numbers of advocates will put pressure on the current system. The committee is also concerned about DVA being responsible for the training of advocates who will then argue against the decisions of DVA officers on behalf of veterans. **The committee is recommending the establishment of a Bureau of Veterans' Advocates (BVA)** institutionally modelled on the Bureau of Pensions Advocates in Canada. This would

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1 Tabled 17 March 2016. The recommendation was agreed in principle by the government.

consist of a section of legally trained public servants with a mission to independently assist and advocate for veterans in making claims. The BVA will supplement and support the current system of volunteer advocates. Where necessary, the BVA will be allocated a budget to commission legal aid to assist veterans make appeals. The BVA will also take over responsibility for grants to ESOs regarding advocacy, training and accreditation of volunteer advocates and insurance issues (see Chapter 7).

Finally, the committee acknowledges that there is substantial support being committed by the Australian Government and considerable work being undertaken by DVA to transform the client experience for veterans. It is encouraging that DVA's reform agenda appears to be moving in the same direction as the recommendations suggested by many submitters. The areas highlighted in the Budget 2017-18 for the ADF and DVA also respond to several of the concerns raised during the inquiry. Nevertheless the pace of reform has been slow and needs to be increased. The committee hopes that the recommendations in this report will contribution to this reform.

Chapter 1
Introduction

Referral

1.1 On 1 September 2016, Senator Lambie, also on behalf of Senators Xenophon, Hinch and Culleton, moved that the Senate note that:

(i) the number of veterans who have served overseas in war and warlike circumstances since 1999 is some 50 000 personnel over 75 000 deployments which is now approaching the number of Australian veterans who served in Vietnam – 60 000 between 1962 and 1972;

(ii) some reports from ex-service organisations and former Australian Defence Force (ADF) members suggest that the number of veterans in our community who have committed suicide may be more than 280 veterans since 1999;

(iii) the Turnbull Government must now take steps to acknowledge this crisis among so many ADF veterans, and undertake the necessary research so as to measure the scale of the suicide rate;

(iv) some ex-service organisations and former ADF members believe that the complexity of Australia's military compensation schemes, together with administrative failures and slow decision-making by the Department of Veterans' Affairs (DVA), is a contributing factor to imposing financial hardship, stress on families, delays in medical treatment, and even homelessness and suicide; Australian Military Compensation Arrangements must be fair and provide former members of the Defence Force and their families who suffer a service injury or disease with a strong system of compensation and other benefits;

(v) media reports and discussions with individual veterans, along with feedback from ex-service organisations have revealed a number of serious issues with the administration, governance and processes of DVA was over five years ago and is now outdated and the Turnbull Government must commit to undertaking a thorough review of DVA, addressing the issues above; and

(vi) the RSL Tasmania State Executive supports the following motion by State President Robert Dick: 'As a society, we have an obligation to ensure that we care for those called upon to serve and defend our country. When there is a failure in the system that looks after and cares for these people, it is important to understand why that failure has occurred and to rectify it to ensure that it doesn't happen again. A Senate inquiry is the most appropriate vehicle to explore these failures and identify the best means to remedy this situation and hold those responsible for the failures to account'.[1]

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1 *Senate Hansard*, 1 September 2016, p. 374.

1.2 The Senate then referred the following matters to the Foreign Affairs, Defence and Trade References Committee for inquiry and report by 30 March 2017:

a. the reasons why Australian veterans are committing suicide at such high rates;

b. previous reviews of military compensation arrangements and their failings;

c. the Repatriation Medical Authority's Statements of Principles, claims administration time limits, claims for detriment caused by defective administration, authorised medical treatment, level of compensation payments, including defence abuse, as contained in all military compensation arrangements;

d. to investigate the progress of reforms within DVA;

e. the administration of claims by DVA and the legislative or other constraints on effective rehabilitation and compensation for veterans; and

f. any other related matters.[2]

1.3 On 27 March 2017, the Senate extended the reporting date of the inquiry to 20 June 2017.[3] On 19 June 2017, the Senate agreed to further extend the reporting date to 15 August 2017.[4]

Conduct of inquiry

1.4 The committee requested that submissions to the inquiry be received by 7 October 2016, however the committee determined that it would continue to consider and accept submissions after this date. The committee also published the following statement regarding the inquiry on its website:

> In terms of setting expectations, the committee emphasises that it is not in a position to address individual claims of rehabilitation or compensation for veterans and ex-service personnel. The committee's focus is on the broad issues raised in the terms of reference of the inquiry.
>
> The committee recognises that this inquiry will deal with matters which could be distressing for some persons. Persons interested in the inquiry who are seeking support or information about suicide prevention are able to contact a number of organisations including:
>
> - Lifeline on 13 11 14;
> - the Veterans and Veterans Families Counselling Service on 1800 011 046; and
> - MensLine on 1300 78 99 78.

2 *Journals of the Senate*, 1 September 2016, p. 101.

3 *Journals of the Senate*, 27 March 2017, p. 1170.

4 *Journals of the Senate*, 19 June 2017, p. 1472.

1.5 The inquiry received 458 submissions, with many accepted as name withheld or taken as confidential by the committee. Due to the complex and sensitive nature of material received of the inquiry there were delays between the receipt and the publication of some submissions. Public submissions are listed at Appendix 1 and are available on the committee's website. Tabled documents, responses to questions on notice and additional information received are listed at Appendix 2.

1.6 The committee held five public hearings for the inquiry and sought to speak to ranges of persons, experts and public officials. The dates and location of the public hearings were:

- 17 November 2016, Adelaide, South Australia;
- 18 November 2016, Canberra, ACT;
- 2 February 2017, Brisbane, Queensland;
- 6 February 2017, Canberra, ACT; and
- 5 May 2017, Perth, Western Australia.

1.7 The witnesses who appeared at these hearings are listed at Appendix 3 and the programs and *Hansard* transcripts are published on the committee's website.

Previous parliamentary inquiries

1.8 Recent parliamentary inquiries have considered topics touching on aspects of the terms of reference and have informed the committee's consideration of this inquiry. These include:

- Senate Foreign Affairs Defence and Trade Legislation Committee, *Safety, Rehabilitation and Compensation Legislation Amendment (Defence Force) Bill 2016 [provisions]* (tabled February 2017);
- Senate Foreign Affairs Defence and Trade References Committee, *Mental health of Australian Defence Force members and veterans* (tabled March 2016);
- Senate Foreign Affairs Defence and Trade Legislation Committee, *Veterans' Affairs Legislation Amendment (2015 Budget Measures) Bill 2015— Schedule 2* (tabled September 2015);
- Senate Foreign Affairs Defence and Trade References Committee, *Processes to support victims of abuse in Defence* (tabled October 2014);
- Joint Standing Committee on Foreign Affairs, Defence and Trade, *Care of ADF Personnel Wounded and Injured on Operations* (tabled June 2013); and
- Senate Foreign Affairs Defence and Trade References Committee, *Report of the DLA Piper Review and the government's response* (tabled June 2013).

1.9 In particular, the Australian Government provided a response to the committee's inquiry on the *Mental health of Australian Defence Force members and veterans* in September 2016.

National Mental Health Commission report

1.10 A number of significant policy developments relevant to the terms of reference have occurred during the inquiry. In particular, on 11 August 2016, the Australian Government announced a review of suicide and self-harm prevention services available to veterans and ADF members. The review was undertaken by the National Mental Health Commission (NMHC), in conjunction with clinical experts and a reference group comprising current and former members of the ADF, the Chair of the Prime Ministerial Advisory Council on Veterans' Mental Health and the Deputy President of the Repatriation Commission.[5]

1.11 The NMHC released its final report and recommendations on 28 March 2017.[6] The report made 23 recommendations including that the Minister 'within six months of receiving this report, and annually thereafter…table a report in the Parliament of Australia, addressing the actions taken in support of implementing the recommendations, and the progress achieved'.[7]

1.12 The Australian Government response to the NMHC report recommendations was released on 30 June 2017. The response included that the Minister would 'deliver an annual Ministerial statement on key issues for current and former serving ADF members and their families' with the first scheduled for August 2017.[8]

Structure of the report

1.13 Chapter 2 of the report provides a background to the inquiry, including an overview of some key entitlements under the three main legislative schemes. Reflecting the terms of reference and the evidence received, the next chapters of the report address three major topics. These are:

- Chapter 3 – suicide by veterans;
- Chapter 4 – the legislative framework; and
- Chapter 5 – administration issues.

1.14 The period when ADF members transition to civilian life was emphasised during the inquiry as a critical time for the provision of assistance. Issues in relation to transition are addressed in Chapter 6.

1.15 Chapter 7 contains discussion of a number of other related matters which were raised. These include:

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5 DVA, *Submission 156*, p. 2.

6 NMHC, *Review into the Suicide and Self-Harm Prevention Services*, March 2017, available at https://www.dva.gov.au/sites/default/files/files/publications/health/Final_Report.pdf (accessed 10 April 2017) (NMHC report).

7 NMHC report, p. 55.

8 *Australian Government response to National Mental Health Commission Review into the Suicide and Self-Harm Prevention Services available to current and former serving ADF members and their families*, 30 June 2017, p. 72 (Government response to NMHC report).

- access to alternative and complimentary therapies;
- advocacy issues; and
- appeals.

Definitions and language

1.16 The committee has tried to be careful not to inadvertently exclude any person or group in conducting this inquiry. However, while circumstances of currently serving ADF members are clearly relevant to parts of the inquiry, the inquiry's terms of reference are directed to the situation of ADF members following the conclusion of their service.

1.17 In particular, the committee acknowledges that the term 'veteran' can mean different things to different people.[9] The *Veterans' Entitlement Act 1988* (VEA) defines a veteran as a person who is 'taken to have rendered eligible war service'; and the term is not specifically defined by the *Military Rehabilitation and Compensation Act 2004* (MRCA), rather it notes the kinds of service to which the MRCA applies, listing warlike service, non-warlike service, peacetime service and defence service.[10] For convenience, the committee has decided to use the term 'veteran' inclusively in this report to describe all former members of the ADF.

1.18 Suicide is a topic that should be discussed carefully and sensitively. Inappropriate discussion and reporting of suicide can be distressing for people bereaved by suicide and can have a negative influence on those at risk. However, the committee has a responsibility to clearly and accurately examine on this significant issue for veterans and their families. While efforts have been made to use appropriate language in this report, evidence from submissions and witnesses have not been edited if potentially inappropriate language has be used.

Acknowledgements

1.19 The committee recognises that for some persons this inquiry has involved discussing difficult topics and revealing extremely personal information. The committee wishes to thank all those who contributed to the inquiry through preparing submissions, providing additional information, speaking to the committee and giving evidence at the public hearings.

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9 For example, this issue was raised in submissions such as by the Defence Force Welfare Association (Queensland) (DFWA Qld), *Submission 148*, p. 2, Alliance of Defence Service Organisations (ADSO), *Submission 172*, p. 1 and Returned and Services League of Australia (RSL), *Submission 216*, p. 4.

10 *Veterans' Entitlement Act 1988*, subsection 5C(1); *Military Rehabilitation and Compensation Act 2004*, subsection 6(1).

Chapter 2
Background

Introduction

2.1 This chapter will outline some background information in relation to the inquiry. In particular, it will provide an overview of key entitlements available to veterans under the three main legislative schemes. These are the *Veterans Entitlement Act 1987* (VEA), the *Safety, Rehabilitation and Compensation Act 1988* (SRCA) and the *Military, Rehabilitation and Compensation Act 2004* (MRCA).

Overview of key veteran entitlements

2.2 Arrangements for pensions, compensation, rehabilitation, health care and other benefits for current and former members of the Australian Defence Force (ADF) and their dependents have changed over time. This has resulted in some ADF members and veterans being covered under different and multiple schemes depending on their service. In particular, the VEA and the SRCA may apply to those with service before 1 July 2004. The MRCA was enacted to provide rehabilitation and compensation for a range of persons who served on or after 1 July 2004.

Health services

2.3 Health services to DVA clients are usually provided through Gold and White Cards which allow access to a range of public and private health care services which are provided at the cost of DVA.[1] The *DVA Health Card – All Conditions within Australia* and *DVA Health Card – Totally & Permanently Incapacitated*, known as the Gold Card, provides eligible veterans with access to a wide range of public and private health care services within Australia for the treatment of health care conditions both related and unrelated to war service.

2.4 The *DVA Health Card – Specific Conditions*, known as the White Card, provides eligible veterans with access to a wide range of public and private health care services within Australia for the treatment of disabilities and conditions accepted as war or service related. The White Card is for the treatment of specific conditions according to clinical need.

2.5 Covered health and care related services include medical consultations and procedures as well as medical specialist services listed by the Medical Benefits Scheme (MBS). The DVA does not generally fund health and related care services not listed on the MBS unless under special circumstances.

Veterans Entitlement Act

2.6 DVA explained that the VEA was a consolidation of a number of pieces of legislation, starting in 1920, that had progressively extended eligibility for repatriation

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1 There is also a *DVA Health Card – Pharmaceuticals Only*, known as the Orange Card, which provides subsidised pharmaceuticals and medicines under the Repatriation Pharmaceuticals Benefits Scheme (RPBS) for medical conditions according to clinical need.

benefits to veterans of different conflicts. It noted that the VEA 'has a focus of lifetime fortnightly non-taxed, non-means tested disability and widow's pension and health care, with little rehabilitation focus'.[2] Repatriation Commission is responsible for granting pensions, allowances and other benefits, providing treatment and other services and generally administering the VEA.

2.7 Pensioners under the VEA are the largest group of DVA clients (225,933) and the largest group of these clients receive the service pension (108,944). A service pension can be paid to veterans with qualifying service on the grounds of age or invalidity, and to eligible partners, widows and widowers. It is subject to an income and assets test. The service pension singles rate is $888.30 and the rate for couple is $669.60 per fortnight.

2.8 DVA clients under the VEA also include 89,797 disability pensioners. There are four rates of the disability pension. The general rate is linked to an individual's level of assessed impairment using the *Guide to the assessment rates of veterans' pensions* (GARP). The general rate is payable in multiples of 10 per cent ($55.43 per fortnight) up to 100 per cent ($485 per fortnight).

2.9 The intermediate rate disability pension is payable where a person is assessed as having a 70 per cent or more disability (using the assessment for the general rate) and it is also assessed that the person is unable to work for at least 20 hours a week (or more than 50 per cent of full-time hours normally worked). The intermediate rate is $926.20 per fortnight.

2.10 The special rate disability pension is often referred to as the totally and permanently incapacitated (TPI) disability pension. The special rate can be payable where a person is assessed as having a 70 per cent or more disability and is assessed as unable to work for at least eight hours a week. The special rate is $1,364.30 per fortnight.

2.11 The extreme disablement adjustment (EDA) rate disability pension can be available for veterans who are 65 years of age and who are entitled to a disability pension at 100 per cent general rate but are not eligible to receive a special rate or intermediate rate pension. Work tests are not applied; instead a test requiring 70 medical impairment points or more and at least six out of seven lifestyle points (determined under the GARP) is applied to qualify for EDA. The EDA rate is $753.60 per fortnight.

Safety, Rehabilitation and Compensation Act

2.12 The SRCA provides compensation coverage to all Commonwealth employees and is administered by Safety, Rehabilitation and Compensation Commission. The SRCA is also administered by DVA, with Part XI extending coverage to ADF members and former members for injuries and illnesses linked to service between

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2 *Submission 156*, p. 31.

1 December 1988 and 1 July 2004.[3] It originally covered only peacetime Defence service but was extended to operational service from 1994, and applies to service up to 1 July 2004. DVA noted:

> The SRCA encompasses the preceding legislation of 1930 and 1971 in that claims relating to injuries/diseases prior to 1988 are compensated under the provisions of the relevant prior scheme. It has a model of lump sum permanent impairment for non-economic effects of injuries/diseases and incapacity payments for economic loss based on pre-injury earnings, a rehabilitation focus, and health care for accepted injuries/diseases.[4]

2.13 Under the SRCA compensation in the form of a lump sum is paid for the functional loss, pain and suffering and the lifestyle effects from injury or disease accepted as related to SRCA service. DVA noted:

> The maximum SRCA [permanent impairment] compensation is currently $251,672 tax-free lump sum for permanent impairment and non-economic loss (indexed). The *Defence Act 1903* provides for payment of a Severe Injury Adjustment (SIA) if an assessed degree of impairment due to specified SRCA injury or disease is at least 80%. SIA provides for a maximum lump sum of $78,235 with an additional $85,750 for each dependent child.[5]

2.14 Incapacity payments are economic loss compensation payments for the inability (or reduced ability) to work because of a service injury or illness:

> Under the SRCA, weekly, taxable, incapacity payments for loss of earnings are paid at 100% of normal weekly earnings, reducing to 75% after 45 weeks in receipt of compensation with payments ceasing age 65. These payments, both at 100% and 75% of normal weekly earnings, are less a 5% notional superannuation contribution.[6]

2.15 The costs of treatment for accepted conditions are generally met through a White Card which will cover all reasonable medical, hospital, pharmaceutical and other treatment costs related to the compensable injury or disease.

2.16 Persons who receive compensation under the SRCA may also be able to claim compensation under the VEA. There are 'offsetting' provisions intended to prevent compensation being provided under both the SRCA and the VEA for the same injury or disease. Compensation received under the SRCA can affect the disability pension or income support pension received under the VEA.

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3 This situation may be altered if the Safety, Rehabilitation and Compensation Legislation Amendment (Defence Force) Bill 2016 (currently before the House of Representatives) is passed.

4 DVA, *Submission 156*, p. 31.

5 DVA, *Submission 156*, p. 21.

6 DVA, *Submission 156*, p. 22.

2.17 Claims for ADF members under the SRCA are determined by delegates of the Military Rehabilitation and Compensation Commission (MRCC) within DVA.[7] As at March 2017, there were 51,926 DVA clients under the SRCA. These included 13,226 permanent impairment payees, 1,800 incapacity payees and 751 open rehabilitation cases.[8]

Military Rehabilitation and Compensation Act 2004

2.18 The MRCA was introduced to replace the VEA and SRCA and to provide a rehabilitation and compensation scheme which combined the features of the VEA and SRCA and covered all types of ADF service from 1 July 2004.[9] Under the MRCA there are a range of benefits available where liability for a service-related condition has been accepted. These include:

- permanent impairment (lump sum) compensation;
- incapacity benefits (due to an inability or reduced ability to work);
- rehabilitation (both vocational and non-vocational);
- medical treatment (including the Gold Card);
- household and attendant care services; and
- compensation for the dependants of deceased members – including bereavement payments, lump sums, funeral expenses, medical treatment (via the provision of a DVA Health Card (Gold)) and compensation for the cost of obtaining financial advice.[10]

2.19 Under the MRCA there are three types of service: warlike service; non-warlike service; and peacetime service. Lump sum payments for ADF members who are injured or contract a disease that is related to warlike and non-warlike service are calculated at a higher rate than those members who were injured on peacetime service. However, members who are eligible for maximum permanent impairment compensation get the same amount, irrespective of the type of service which caused the impairment:[11]

> Permanent impairment compensation payments are non-economic loss payments; that is, they are paid to compensate for pain, suffering, functional loss or dysfunction and the effects of the injury or disease on lifestyle. Under the [MRCA], when liability for an injury or disease that results in permanent impairment has been accepted, the MRCA allows compensation

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7 DVA, 'Overview of the Safety, Rehabilitation and Compensation Act 1988 (SRCA)', *Factsheet MCS01*, p. 1.

8 DVA, *Stats at a Glance*, March 2017.

9 *Submission 156*, p. 31.

10 DVA, 'Overview of the Military Rehabilitation and Compensation Act 2004 (MRCA)', Factsheet MRC01, 13 October 2016, p. 1.

11 DVA, 'Overview of the Military Rehabilitation and Compensation Act 2004 (MRCA)', Factsheet MRC01, 13 October 2016, p. 1.

to be paid periodically, currently a weekly amount of $335. In the case of a 30-year-old male, the MRCA weekly amount can be converted into a lump sum of up to $448,971.[12]

2.20 For incapacity payment under the MRCA, weekly, taxable, incapacity payments for loss of earnings are paid at 100 per cent of normal earnings reducing to 75 per cent after 45 weeks after discharge and cease at age 65.

2.21 The Special Rate Disability Pension (SRDP) payment provides an alternative form of periodic compensation (instead of incapacity payments) for veterans whose capacity for work has been severely restricted because of conditions suffered due to military service. Veterans eligible for the SRDP are offered a choice in writing and required to obtain financial advice. The choice between the SRDP and incapacity payments cannot be changed. Those eligible for the SRDP receive a Gold Card. Participation in rehabilitation is a precondition to being assessed as eligible for the SRDP.[13]

2.22 As at March 2017, there were 25,224 DVA clients under the MRCA. These included 9,028 permanent impairment payees, 3,121 incapacity payees and 2,040 open rehabilitation cases.[14]

Non-liability Health Care

2.23 Non-liability health care is coverage by DVA for health treatments without the need to establish a link to service or recognise liability for providing compensation. Under these arrangements veterans with certain service may be eligible for treatment of cancer (malignant neoplasm), pulmonary tuberculosis and mental health conditions. In the 2016-17 Budget, the Government announced that it would extend non-liability health care for certain mental health conditions to all current and former ADF members, irrespective of their date, duration or type of service.[15] From 1 July 2017, this was extended to treatment of all mental health conditions.

2.24 This could include treatment from a general practitioner, medical specialist, psychologist, social worker, occupational therapist, psychiatrist, hospital services, specialist PTSD programs, pharmaceuticals, or oncologist services as required. Veterans who are eligible are issued with a *DVA Health Card – for specific conditions* (White Card).[16]

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12 DVA, *Submission 156*, p. 21.

13 DVA, 'Special Rate Disability Pension (SRDP)', Factsheet MRC09, 13 July 2017.

14 DVA, *Stats at a Glance*, March 2017.

15 DVA, *Budget paper no. 2: Budget measures 2016-17*, p. 155.

16 DVA, 'Non-Liability Health Care', *Fact Sheet HSV109*, 1 July 2017, p. 1.

Chapter 3
Suicide by veterans

Introduction

3.1 The first term of reference of the committee's inquiry is 'the reasons why Australian veterans are committing suicide at such high rates'. This chapter will consider issues relating to this term of reference. This includes the incidence of suicide by ADF members and veterans, including recent results by the Australian Institute of Health and Welfare (AIHW). On-going and future research into the welfare of veterans including mental health issues and suicidality will be examined. It will consider the range of identified contributing factors to suicide by veterans and the approach of DVA to suicide prevention. Finally, this chapter will examine issues relevant to veterans accessing appropriate mental health assistance.

The incidence of suicide

Suicide in Australia

3.2 Suicide is a leading cause of death in Australia. A suicide occurs when a person dies as a result of a deliberate act intended to cause the end of his or her life. In 2015, 3,027 people died from intentional self-harm. This is up from 2,864 in 2014. The age-standardised death by suicide rate was 12.6 per 100,000 persons and it is the 13th leading cause of death. In 2015, suicide was the leading cause of death among all people 15-44 years of age and the second leading cause of death among those 45-54 years of age.[1]

3.3 Around three quarters of deaths by suicide are male. Attempted suicide is also an important health issue with estimates that as many as 30 people attempt to end their lives for every death by suicide, the majority being women. For Aboriginal and Torres Strait Islander peoples the suicide rate is more than double the national rate.[2]

Suicidality in ADF population

3.4 The 2010 ADF Mental Health Prevalence and Wellbeing Study (MHPW study) found that the rate of suicidality (thinking of suicide and making a suicide plan) in the ADF was more than double that in the general community; however the number of suicide attempts was not significantly greater than in the general community and the number of reported deaths by suicide in the ADF were lower than in the general population when matched for age and sex.

3.5 The MHPW study found that, although ADF members are more symptomatic and more likely to express suicidal ideation than people in the general community, they are only equally likely to attempt suicide and less likely to complete the act. This

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1 Australian Bureau of Statistics, *Australia's Leading Causes of Death*, September 2016.

2 Australian Bureau of Statistics, *Australia's Leading Causes of Death*, September 2016.

suggested that 'the comprehensive initiatives on literacy and suicide prevention currently being implemented in Defence may, in fact, be having a positive impact'.[3]

3.6 Defence advised the committee that between 1 January 2000 and 29 September 2016, 118 full-time serving ADF members were suspected or confirmed to have died by suicide. Of these 37 were with the Royal Australian Navy, 60 with Australian Army and 21 with the Royal Australian Air Force (as at 20 September 2016). Eight were female.[4]

3.7 Defence commented that for serving ADF members, based on the available data, there does not appear to be any discernible trend in the number of deaths by suicide nor is there any clear association with operational deployment. Of the 118 ADF members confirmed or suspected to have died by suicide 64 had never deployed. Of the 54 who had deployed, 22 had one or more deployments to the Middle East Area of Operations.[5]

Suicidality in ex-service population

3.8 DVA reported that '[a]s at 31 March 2016, DVA has determined claims in relation to 83 deaths by suicide in the ten years to 31 December 2015'. Of these 56 were accepted by DVA as service related.[6] DVA also outlined the practical difficulties in assessing deaths by suicide in the veteran community. While DVA indicated that it was working with other agencies to improve understanding of the prevalence of suicide among ex-serving personnel, it has previously acknowledged that it 'is unlikely to ever obtain complete information in relation to the prevalence of suicide amongst all those who have served with the [ADF]'.[7]

3.9 DVA generally only becomes aware of a former member's death by suicide if a dependant submits a claim for compensation or income support. During the inquiry, the Returned & Services League (RSL) noted that this meant that if 'veterans do not have dependents and a claim is not lodged then the cause of death will not be recorded by DVA'. Furthermore:

> Death can be 'automatically' accepted in a range of situations…In situations where there is an 'automatic' acceptance of death and the subsequent granting of benefits to the dependents, or where the veteran had no dependants, there will be no recording of the cause of death centrally through DVA, regardless of whether a coroner may have determined that the cause of death was suicide.[8]

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3 Defence, *Mental Health in the Australian Defence Force: 2010 ADF Mental Health Prevalence and Wellbeing Study Report*, p. xiv.

4 Defence, *Submission 124*, p. 5.

5 Defence, *Submission 124*, p. 6.

6 DVA, *Submission 156*, p. 3.

7 DVA, responses to questions on notice from public hearing on 13 August 2014, p. 2.

8 *Submission 216*, p. 8.

Australian Institute of Health and Welfare

3.10 In 2016, the AIHW was commissioned by DVA to calculate accurate numbers and rates of suicide deaths among serving personnel, reservists and ex-serving ADF personnel. Key information was derived from the Defence PMKeyS database, the National Death Index (NDI), the Defence Suicide Database and the National Mortality Database. The AIHW report noted:

> Cause of death (suicide) data were obtained only from certified sources; that is, official fact of death and cause of death determination (including suicide death) from the Registrars of Births, Deaths and Marriages in each state and territory and the National Coronial Information System…Reporting only certified deaths ensures that the results presented here are defensible, comparable over time and can be reproduced. Differences between the results of this study and other publicly reported estimates may be due to differences in scope and/or the source of cause of death information.[9]

3.11 Before the AIHW results were released, DVA cautioned that there would be data limitations. It noted that the specific time-range of the cohort considered 'means it's not possible to extrapolate the findings to the broader ex-serving community' and it would not be possible to 'simply compare counts of death due to suicide between the different services types and the Australian population'.[10]

3.12 On 30 November 2016, the AIHW released its initial study. The AIHW found that between 2001 and 2014, there were 292 certified suicide deaths among people with at least one day of ADF service since 2001. Of these:

- 84 occurred in the serving full-time population;
- 66 occurred in the reserve population;
- 142 occurred in the ex-serving population; and
- 272 were men and 20 were women.[11]

3.13 In particular, the AIHW study found that after adjusting for age, when compared with all Australian men, that men serving full-time and in the reserve had a lower suicide rate (53 per cent and 46 per cent). However, the suicide rate for ex-serving men was 13 per cent higher. It noted:

> In 2002-2014, younger ex-serving men were at higher risk of suicide death compared with all Australian men of the same age. Among ex-serving men, those aged 18-24 accounted for 1 in 6 suicide deaths (23 deaths, 17%) and

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9 AIHW, *Incidence of suicide among serving and ex-serving Australian Defence Force personnel 2001–2015: in brief summary report*, June 2017, p. 5.

10 *Submission 156*, p. 4.

11 AIHW, *Incidence of suicide among serving and ex-serving Australian Defence Force personnel 2001–2014*, November 2016, p. 1.

> had a suicide rate almost 2 times as high as Australian men of the same age. This difference was statistically significant.[12]

3.14 In its summary report, released in June 2017, the AIHW found that between 2001 and 2015, there were 325 certified suicide deaths among people with at least one day of ADF service since 2001. Of these deaths:

- 51 per cent (166) were of people no longer serving at the time of their death;
- 21 per cent (69) were of people serving in the active and inactive reserves at the time of their death;
- 28 per cent (90) were of people serving full time at the time of their death; and
- 93 per cent (303) were men and 7 per cent (22) were women.

3.15 The AIHW stated:

> The suicide rates of ex-serving men were more than twice as high as for those serving full time or in the reserve (26 suicide deaths per 100,000 people, compared with 11 and 12 per 100,000, respectively). They were also slightly higher than for their counterparts in the general population after adjusting for age (14% higher, however this difference was not statistically significant).
>
> Ex-serving men aged 18-24 were at particular risk—2 times more likely to die from suicide than Australian men of the same age.
>
> Ex-serving men aged 25-29 accounted for slightly more deaths than other age groups and were 1.4 times more likely to die from suicide than Australian men of the same age. This difference was not statistically significant.
>
> Men serving full time or in the reserve had significantly lower suicide rates than for men in the general population (53% and 49% lower, respectively), after adjusting for age.[13]

3.16 The AIHW summary report identified several risk groups among ex-serving men. These included:

- suicide rates for ex-serving men aged 18–49 were between 3 and 4 times as high as for men aged 50–84;
- those who were discharged involuntarily (suicide rates were 2.4 times as high as for those discharged for voluntary reasons), particularly if the discharge was for medical reasons (3.6 times as high as for those discharged for voluntary reasons);
- those who left the ADF after less than 1 year of service (2.4 times as high as for those who had served for 10 years or more); and

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12 AIHW, *Incidence of suicide among serving and ex-serving Australian Defence Force personnel 2001–2014*, November 2016, p. 2.

13 AIHW, *Incidence of suicide among serving and ex-serving Australian Defence Force personnel 2001–2015: in brief summary report*, June 2017, p. vi.

- all ranks other than commissioned officers (2.8 times as high as for commissioned officers).[14]

3.17 The AIHW observed that that despite methodological differences, the findings of the study in relation to the influence of age, rank, length of service and time since discharge on rates of suicide were 'consistent with findings from studies of ex-serving defence personnel across the United Kingdom, Canada and the United States'. While it was not possible to analyse the effect of operational service, the AIHW noted that 'as the study progresses and data for more years is added, it may be possible to explore suicide rates' for veterans with these service characteristics in more detail.[15]

Research and data collection

3.18 The AIHW study is a component of a range of research funded by both Defence and DVA into the health and well-being of serving members and veterans, particularly in relation to mental health. For example, Defence and DVA have created a database, the Military and Veteran Research Study Roll (held by AIHW) of contact details of members who transitioned out of the ADF between 2010 and 2014 to facilitate future research.[16]

3.19 A current large scale research project is the Transition and Wellbeing Research Programme (TWRP). This will examine the impact of contemporary military service on the mental, physical and social health of serving and ex-serving personnel and their families, and builds on previous Defence research such as the Military Health Outcomes Program (MilHOP). The TWRP will consist of three major studies:

- Mental Health and Wellbeing Transition Study;
- Impact of Combat Study; and
- Family Wellbeing Study.[17]

3.20 DVA outlined that its strategy for research into mental health was guided by the DVA Corporate Plan 2016-2020 and by the *Veteran Mental Health Strategy (A Ten Year Framework) 2013-2023*:

> The Corporate Plan sets out DVA's commitment to better understanding the health needs of veterans through a continued focus on research over the next four years and beyond, especially in relation to rehabilitation and

14 AIHW, *Incidence of suicide among serving and ex-serving Australian Defence Force personnel 2001–2015: in brief summary report*, June 2017, p. vii.

15 AIHW, *Incidence of suicide among serving and ex-serving Australian Defence Force personnel 2001–2015: in brief summary report*, June 2017, p. 29.

16 DVA, 'Military and Veteran Research Study Roll', available at: https://www.dva.gov.au/health-and-wellbeing/research-and-development/military-and-veteran-research-study-roll (accessed 28 July 2017).

17 CTSS, 'Transition & Wellbeing Research Programme', available at: http://health.adelaide.edu.au/ctss/research/military/transition-wellbeing-research-programme/ (accessed 16 May 2017).

> mental health, with a strong emphasis on early intervention to improve clients' prospects of recovery.
>
> This priority is also reflected in the *Veteran Mental Health Strategy (A Ten Year Framework) 2013-2023*. Under this Strategy, Strategic Objective 6 is "Build the Evidence Base". As a significant purchaser of mental health services, DVA needs a strong evidence base for best practice veteran mental health services, treatments and interventions.[18]

3.21 However, despite these research programs many submitters and witnesses highlighted the problems with current research into veteran suicide and that lack of accurate data collection which could be used to improve the welfare of veterans. For example, the RSL pointed out it was 'currently impossible to tell how many veterans live in Australia today':

> While our best guess that the numbers are between 310,000 (the number of Australian Defence Medals issued by 2010) and 500,000, there is no dataset that can provide a definite number. Similarly, there is currently no dataset that will provide information on the number of veterans receiving healthcare.[19]

3.22 The RSL argued that a 'way of identifying and recording causes of death for all serving members and veterans needs to be established'. It made a number of recommendations for gathering information on veterans through the census, coronial reports, police reports and audits specific cases.[20]

3.23 Suicide is recognised to be an inherently difficult social phenomenon to study due to community stigma, underreporting, and in some circumstances, uncertainty relating to cause of death. In particular, information concerning military and ex-military personnel may have a 'healthy worker' bias, due to recruitment standards and training in the ADF, which meant that the suicide rate amongst serving and ex-serving members cannot be directly compared to the general population. For example, the Vietnam Veterans' Federation of Australia (VVFA) noted:

> ADF members are screened psychologically and medically as part of a rigorous selection procedure. They are then systematically trained to cope with the high levels of physical and emotional demand necessary for sustained performance in operational roles. It is therefore reasonable to hypothesise that the incidence of suicide within currently serving and ex-serving veterans should be less than for the general population, and this hypothesis is supported by research. If it is the same, or higher, then 'something' has intervened, and there is again, research evidence to support that it is higher than would be expected. [21]

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18 DVA, response to written question on notice from 6 February 2017 public hearing.

19 *Submission 216*, p. 5.

20 *Submission 216*, p. 7.

21 *Submission 277*, pp 6-7.

3.24 In July 2016, the Australian Institute for Suicide Research and Prevention (AISRP) published a literature review regarding suicide amongst veterans in Australia and internationally, and how this compares to the general population. One of its findings was that there is 'very limited research information focusing specifically on suicide mortality, non fatal suicidal behaviour or suicidal ideation among individuals who have left the Australian Defence Force'.[22] It described the lack of information about suicide mortality among ex-serving Australian personnel as a 'serious shortcoming in current knowledge'.[23]

3.25 Similar concerns were expressed by submitters. For example, Suicide Prevention Australia also considered '[t]he lack of research comprehensively and specifically addressing suicidal behaviour among Australian veterans is itself an issue: investment in research is urgently required to uncover the reasons Australian veterans and ex-service personnel are dying by suicide and how suicidal behaviour among this population can be prevented'.[24] The South Australian Government also observed that '[w]ithout accurate data it is difficult to fully understand the magnitude of the issue although it is considered that a zero tolerance of suicide amongst the veteran community is a suitable aspirational target and statistical evidence of one suicide is sufficient to warrant serious consideration'.[25]

3.26 There is no national suicide register in Australia, although some states have established registers for their jurisdictions. Dr Kairi Kolves from the AISRP, which administers the Queensland Suicide Register, underscored the difficulties in identifying veterans who have taken their own lives:

> Identifying ex-serving members is pretty challenging, because when police arrive at the scene, there is often no information as to whether the person has been an ex-serving member, unless it is indicated by family members who knew about it. If the informant happens to be somebody else, it is likely that they will miss it. A similar thing happens with the National Coronial Information System.[26]

3.27 The lack of an official register of serving and ex-serving members who commit suicide was highlighted during the inquiry. Growing awareness regarding suicide by ex-service men and women has led to members of the community such as the *Australian Veterans Suicide Register* to unofficially highlight incidence of suicide.[27] Some raised concerns with the committee that the lack robust official

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22 AISRP, 'Suicidal behaviour and ideation among military personnel: Australian and international trends', *Technical report*, July 2016, p. 18.

23 AISRP, 'Suicidal behaviour and ideation among military personnel: Australian and international trends', *Technical report*, July 2016, p. 28.

24 *Submission 176*, p. 2.

25 *Submission 187*, p. 3.

26 *Committee Hansard*, 2 February 2017, p. 2.

27 Available at: https://www.facebook.com/AustralianVeteransSuicideRegister/ (accessed 12 July 2017).

statistics would allow 'others to sensationalise suicide on social media' and may contribute to increase suicidal ideation.[28]

3.28 Some submitters supported the introduction of a publicly maintained register of suicide amongst ex-military personnel.[29] Slater and Gordon Lawyers argued that the data from the AIHW study 'needs to be gathered on a regular basis and made publicly available in a de-identifiable format'. It considered that this was 'only way that the extent of the issue can be properly quantified and understood, and then steps toward a meaningful solution strategy taken'.[30] Mr Arthur Ventham proposed that a '[m]ilitary suicide register should be funded to collect the true number of service and ex-service suicides' with cross-matched data from state coroners' offices, the ADF and police.[31] The Catholic Women's League of Australia also urged the Australian Government to establish a 'government funded and managed data base/register on suicide':

> Data collection is paramount to gaining a better understanding of how widespread suicide is in the armed forces, and being able to take steps to support those who need support and prevent it from happening. Without an accurate snap shot of the magnitude of the problem efforts to rectify the situation can only be half-hearted at best. Furthermore, a lack of data results in a lack of research and national plan formulation on the issue, only serving to exacerbate the stigma and shame that is so prevalent around this issue. However, this is an initiative that needs to be supported, funded and managed by the Australian government, to ensure consistency and accuracy of data.[32]

3.29 Relevant areas for further research were also highlighted. For example, Dr Andrew Khoo, a consultant psychiatrist, recommended work into 'concepts which are recently coming under the heading of "Moral injury" and their possible contribution to suicidal behaviour'. Moral injuries could include 'guilt over what was or wasn't done and coming to terms with perceived betrayals and losses'. He noted that 'young men and women have difficulty resolving the deprivation, disease and death they have encountered, and the horror of what one human can do to another'.[33]

3.30 The NMHC report considered that '[c]ontinued research is required to develop a comprehensive understanding of suicide and self-harm within current and former members of the ADF, and their families. It supported the development of a long-term research program focussed on mental health and wellbeing, and the prevention of suicide and self-harm in conjunction with expert bodies and taking in account current research such as the TWRP and the AIHW. In particular, the NMHC recommended:

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28 For example, Ms Julia Langrehr, *Committee Hansard*, 17 November 2016, p. 46.

29 For example, Slater and Gordon Lawyers, *Submission 160*, p. 7.

30 *Submission 160*, p. 7.

31 *Submission 295*, p. 12.

32 *Submission 405*, p. 4.

33 *Submission 155*, p. 7; also Mr Gordon Smith, *Submission 230*, p. 5.

> The Department of Defence should periodically commission (e.g. every 2-5 years) repetition of the data-linking study undertaken by the AIHW that examined the risk of suicide in current and former serving members. It is only in this way that a more accurate picture of the true risk of suicide can be built up over the next generation of military service.[34]

3.31 In its response to the NMHC report, the Australian Government stated that it intended 'that AIHW provide regular updates on the suicide data linkage study to improve the understanding of the true risk of suicide'. It noted that DVA and Defence were 'currently in discussion with AIHW for the continuation and regular updating of this study'.[35]

Identified contributing factors

3.32 A broad range of interrelated factors were identified as contributing to the incidence of suicide by veterans. These included both factors which affect the general population and factors which were linked to the experiences of those persons who have served in the ADF. In the general community, DVA noted that 'factors can include pain, despair, guilt, shame, recklessness or an expression of a person's right to choose the manner of their death'.[36] Phoenix Australia listed a number of identified risk factors associated with suicide including:

- historical factors, such as any history of suicide attempts, past abuse, family history of suicide, and family history of mental health problems;
- mental health factors, such as current mental health problems and recent discharge from an inpatient mental health unit;
- demographic factors, such as male gender and divorced or widowed marital status, with peaks between the ages of 40-54 and over 80;
- social factors, such as social isolation, loss of relationship, financial difficulty, and critically, having access to means for suicide; and
- medical factors, such as chronic pain and physical health problems.[37]

3.33 The recent AISRP report on 'Suicidal behaviour and ideation among military personnel: Australian and international trends' noted that a 'qualitative analysis of the case studies concluded that the reasons for suicide among veterans are multidimensional and include a range of veteran-specific risk factors such as difficulty returning to civilian life (relationship problems, mental illness, alcohol and drug misuse, employment problems, bereavement, and loss of the routine and structure that

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34 NMHC report, p. 55.

35 Government response to the NMHC report, p. 72.

36 *Submission 156*, p. 1.

37 *Submission 177*, p. 2.

characterise a military lifestyle) and veterans' reluctance to seek help for their problems'.[38]

3.34 Submitters to the inquiry highlighted a range of issues which contribute to veteran suicide, self-harm and ideation. These included:

- mental health issues, including depression and post-traumatic stress disorder (PTSD);
- homelessness, poverty and lack of income;
- unemployment and low job security;
- stress on personal relationships and family violence;
- social isolation and lack of connectedness;
- experiences of sexual assault, bullying and harassment in the ADF;
- perceived maladministration within the military justice system;
- the side effects of mefloquine (anti-malarial drugs); and
- substance and alcohol abuse.

3.35 Suicide Prevention Australia recommended consideration of Thomas Joiner's interpersonal-psychological theory of suicidal behaviour which posits three key factors in determining the risk of an individual engaging in a lethal suicide attempt. These factors were 'perceived burdensomeness', 'thwarted belongingness', and 'acquired capability for suicide'. It detailed how these factors were relevant to the experiences of veterans.[39] Similarly, Dr Frank Donovan, a former mental health social worker, noted:

> Suicide has commonly been associated with experiences like alienation from family, community, previous friendship networks, employment and even intimate partners – leaving the potential suicide with no support, sense of self-worth, future or a 'life worth living'. Bereft of their former military milieu which provided for all of these important features of life, suicide is perhaps seen as the 'best way out' of the veterans new sense of meaninglessness.[40]

3.36 Dr Andrew Khoo outlined the risk factors for suicide identified by the US based Center for Disease Control and Prevention which included a 'history of mental disorders' and 'physical illness'. He noted:

> Exposure to trauma (either during deployment, training exercises or workplace accidents/incidents) during military service is associated with increased risk of psychological injury. Depending on which research you peruse 12 month prevalence rates for mental disorders vary between 20-

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38 AISRP, 'Suicidal behaviour and ideation among military personnel: Australian and international trends', *Technical report*, July 2016, pp 18-19.

39 *Submission 176*, pp 3-5.

40 *Submission 257*, p. 2.

> 30% for returned service people, with lifetime prevalence rates of greater than 50%. These rates are significantly higher than matched civilian cohorts. Suicide research informs us that up to 90% of completed suicides have diagnosable mental illness.
>
> Comorbidity rates of Alcohol and Drug Use Disorders in populations with combat related PTSD are as high as 60-80%. Recent US VA statistics show that 1 in 10 returning personnel have an active drug or alcohol problem. Whilst the general trend is for serving personnel to have decreased rates of Substance Use Disorders (SUDs) compared with the civilian population (ADF prevalence study, US DoD statistics), rates of SUDs accompanying PTSD and other mental health disorders following service are significant. Of concern is the effect of both Australian and military culture which has historically advocated alcohol use as a coping mechanism for stress. Particularly as alcohol and/or drug intoxication reduces judgment making suicide attempt and success more likely…
>
> There are a number of chronic physical conditions which typify the medical presentation of serving and ex serving military personnel. These include hearing loss, tinnitus, degenerative osteoarthritic conditions of weight bearing joints (ie the neck, shoulders, lower back, hips, knees and ankles), gastro-oesophageal reflux disease, irritable bowel syndrome and sexual dysfunction. These chronic conditions covey significant pain, disability and impairment and hence may contribute to numerous functional losses and a sense of loss of worth, hope or esteem.[41]

3.37 The unique nature of military training and the impacts of the stress caused by training to veterans was also highlighted. For example, the Defence Force Welfare Association (Queenland) observed that '[f]rom the outset, ADF members are deliberately exposed to violence and are trained to react and continue working in stressful and often dangerous situations'. It noted that there have been many major and minor accidents where ADF members have been injured and/or killed on duty whilst training for war. It stated that 'training environment stressors can have a deleterious effect on the mental health of individuals whether or not they make it through the training program' and suggested that 'this may be a contributing factor in some suicidal events'.[42]

3.38 Recent deployment structures were identified as putting additional stress on some military personnel, with multiple deployments perceived as increasing the risks of the development mental health problems.[43] Limited recovery-time between deployments also was seen as putting additional stress on veterans and their families.[44] For example, Mr Max Ball drew the committee's attention to a U.K. Ministry of

41 *Submission 155*, p. 4.

42 *Submission 148*, p. 2.

43 For example, Mr Allan Thomas, *Submission 399*, p. 3.

44 Ms Narelle Bromhead, *Committee Hansard*, 18 November 2016, p. 15.

Defence recommendation that military personnel be deployed for six months at a time and for less than twelve months in any three-year period.[45]

3.39 While a wide range of factors were identified there were two particular factors which were a focus in the evidence for the inquiry: PTSD and the compensation claims process.

Post-traumatic stress disorder

3.40 Post-traumatic stress disorder (PTSD) is a set of reactions that can develop in persons who have been through a traumatic event which threatened their life or safety, or those around them. Royal Australian and New Zealand College of Psychiatrists (RANZCP) highlighted the 'well-researched correlation between suicidality and PTSD:

> Exposure to traumatic events significantly increases the risk of suicidal ideation and behaviour. The relationship between trauma and suicidality has been found to exist independent of psychiatric disorders although comorbidities with mood and substance abuse disorders may still be factors. Numerous studies have demonstrated a positive relationship between cumulative trauma and suicidality.[46]

3.41 In particular, it emphasised the need for customised treatments for military-related PTSD. The best-practice treatment for patients with PTSD in the general population, may not constitute an apt approach to the treatment of military-related PTSD. It noted:

> There are a number of particular treatments which may present significant benefits for veterans and ex-service personnel but which may be inaccessible or even disallowed. Private hospital day programs and community services are good examples of treatment settings to which veterans require increased access. Family-centred approaches to treatment may also be useful considering the potential effects of mental ill health on the 'families of veterans and ex-service personnel suffering from PTSD.[47]

3.42 The treatability of PTSD was also emphasised by health professionals and experts. For example, Dr Robert Tym highlighted evidence of the effectiveness of Eye Movement Desensitisation and Reprocessing in treating and managing types of PTSD. Dr Kerr from AISRP noted that, with treatment, military personnel can return to being 'deployable again':

> There is this culture that people still think that PTSD or other mental health disorders cannot be gotten rid of. And they can be. We have excellent treatments for some of these disorders, and they go into remission meaning that they no longer have these disorders. And, for those people, there is no reason why they should not still be in the uniform.[48]

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45 *Submission 323*, p. 2.

46 *Submission 165*, p. 9.

47 *Submission 165*, p. 12.

48 *Committee Hansard*, 2 February 2017, p. 7.

The compensation claims process

3.43 Many submitters identified delays, negative determinations or perceived maladministration in DVA the compensation claim processes as creating critical stress for veterans and as a contributing factor to suicide. For example, Suicide Prevention Australia commented that it had 'received feedback from multiple sources that the processes involved in engaging with DVA are perceived to exacerbate veterans' stress and we posit that this may add to the perception of perceived burdensomeness and thwarted belongingness, and therefore suicide risk'.[49] Similarly, the AISRP submission listed a number of risk factors for suicide by veterans, including:

> Unfortunately the DVA compensation system is complex and slow, and provides disincentives to work depending on the compensation Act the person falls under. Additionally, veterans report that they feel a sense of uncertainty regarding their future and feel they cannot progress their lives until their compensation issues are finalised. They explain feeling paralysed, 'in limbo'.[50]

3.44 These concerns regarding the impact of the claims process were also evident in submissions from veterans, their families, advocates and others. For example, John and Karen Bird told the committee about their son Jesse who had been diagnosed with PTSD and other mental health conditions:

> He has been endeavouring to seek assistance from DVA for the last eighteen months without success - it seems to him and us that the level of bureaucracy is intentionally obstructionist and unedifying. The jungle of paperwork, the lack of follow-up and the non-existent support has contributed to his deteriorating mental health. He is involved with VVCS and is currently involved in a 12 Week PTSD Specific Counselling program which finishes in early December. Jesse has not received any money what-so-ever from DVA or Centrelink to help him survive and without our financial and emotional help he would be on the street or worse.[51]

3.45 Subsequently, Jesse took his own life. His former partner, Ms Connie Boglis, outlined the problems Jesse had after his service:

> Jesse did not have a 'Part time' 6-10 scale PTSD, Jesse had PTSD Everyday! Jesse was trained to run into the face of fear, you taught him that. You broke him down before he even left for war and if that wasn't enough, he was deployed to Afghanistan for 9 months when it was only meant to be 6. The day Jesse landed on Australian soil he should have been handed a white card, given a pension and options for supports thereafter if he choose. Instead Jesse was expected to pour out his wounds from the battlefield to a complete stranger and talk emotions, something you taught him to hide so well. Well he did it, Then you made him wait, in hope that his voice would be heard, So we continued to wait, I couldn't wait any

49 *Submission 176*, p. 7.

50 *Submission 174*, p. 3.

51 *Submission 317*, p. 1.

> longer, So Jesse tried to wait a little more and fight on his own but you never came.[52]

3.46 Mr Peter Thornton, another veteran, described the DVA disability claims process as 'challenging' and weighing 'heavily upon one's mental health and well-being, generally at a time when one is at an extremely low ebb'. While he accepted the need for a 'rigorous process that thwarts fraud', he perceived the process itself 'could be a contributing factor to suicidal ideation and/or actual suicide itself, by Veterans who are under immense pressure'.[53] Another veteran, Mr Shaun Young, highlighted the difficulties for those with mental health issues in interacting with DVA:

> When you suffer day to day with major depression, life is already hard to get through. You literally have to take it one day at a time. Then you have to call DVA on one of those days and suddenly you're thinking to yourself 'what's the point of this bulls**t?' You're in a constant battle with yourself and then DVA make it so you have to battle them.[54]

3.47 In this context, Dr Nick Ford, a psychiatrist who works with veterans, drew the committee's attention to a 2014 study which examined the aspects of claims processes that claimants to transport accident and workers' compensation schemes find stressful and whether such stressful experiences were associated with poorer long-term recovery.[55] This study concluded that:

> Many claimants experience high levels of stress from engaging with injury compensation schemes, and this experience is positively correlated with poor long-term recovery. Intervening early to boost resilience among those at risk of stressful claims experiences and redesigning compensation processes to reduce their stressfulness may improve recovery and save money.[56]

3.48 RANZCP noted that there was 'an increasing body of evidence indicating that delays in claim settlement, inappropriate decisions and unnecessary obfuscation in administrative processes can serve to significantly worsen the distress and severity of a veteran's condition'. It believed that 'the compensation system would benefit from a reconceptualisation of compensation as part and parcel of the health-care system to ensure that the processing of justified compensation claims do not adversely affect health outcomes'.[57]

3.49 Others cautioned against focusing on one factor when the issues relating to veteran suicide were clearly complex. For example, the Alliance of Defence Service

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52 *Submission 433*, p. 4.

53 *Submission 335*, pp. 14-15.

54 *Submission 252*, p. 2.

55 *Committee Hansard*, 17 November 2016, p. 6.

56 Genevieve Grant et al, 'Relationship Between Stressfulness of Claiming for Injury Compensation and Long-term Recovery: A Prospective Cohort Study', *JAMA Psychiatry*, 71(4) 2014, pp 446-456.

57 *Submission 165*, p. 2.

Organisations (ADSO) considered that 'DVA's responsibility for contributing to veteran suicidality must, however, be tempered by a reality that seems to suggest that only 20% of people transitioning out of the ADF become automatic DVA clients, and around another 15% eventually become DVA clients after transition has occurred'. Nonetheless, ADSO recommended:

> The perception that the rehabilitation and compensation decision process is unreasonable, oppressive, and runs counter to timely and equitable support, and therefore contributes to veteran suicide, should be investigated. Whether the bureaucratic focus on due process is an exacerbating factor and is contributing to veteran suicide should be investigated.[58]

Suicide prevention

3.50 The government response to the committee's report into the mental health of the ADF members and veterans in September 2016 described suicide prevention 'for serving and former serving ADF members at risk and support to the families who have been affected by the tragedy of suicide' as a 'high priority':

> The Government's current suicide prevention strategy includes training to assist at-risk individuals, programs to build resilience, self-help and educational materials, a 24-hour support line, and access to clinical services. The Government is continuing to invest in initiatives to prevent suicide among current and former serving personnel and support those affected by it. As part of the 2016-17 Budget, funding of $1 million has been provided to continue the suicide awareness and prevention workshops and to pilot an alternative approach to suicide prevention in the veteran community. This is in addition to the $187 million a year that the Government already spends in relation to veteran mental health.[59]

3.51 DVA outlined that the '*Veteran Mental Health Strategy 2013-2023* provides a ten year strategic framework to support the mental health and wellbeing of the ex-service community'. Funding for mental health treatment is demand driven, and is not capped and DVA spends around '$187 million a year on supporting the mental health needs of its clients'.[60]

3.52 The NMHC report contained a useful summary of services available to veterans through DVA. These included:

- post-discharge GP health assessments;
- mental health treatments through:
  - GP, psychologist, psychiatrist, and social work services
  - pharmaceuticals

58 *Submission 172*, p. 8.

59 Government response to Senate Foreign Affairs, Defence and Trade Committee report, *Mental Health of Australian Defence Force Members and Veterans*, September 2016, p. 3.

60 *Submission 156*, p. 5.

  - in-patient and out-patient hospital treatment
- services through Veterans and Veterans Families Counselling Service (VVCS), including a 24-hour crisis line, counselling, group treatment programs';
- DVA's Operation Life suicide prevention program, which includes face-to-face workshops, a website and an app;
- online resources, including DVA's At Ease online mental health portal, PTSD Coach Australia app, High Res website and app (stress and resilience program), and The Right Mix website and On Track with the Right Mix app (alcohol management program); and
- a range of health and wellbeing programs such as Stepping Out (transition program), Day Club, Men's Health Peer education, and Veterans Health Week.[61]

3.53 The NMHC report noted that mental health treatments for former serving members can be delivered by practitioners who are registered to provide services under the Medicare Benefits Schedule (MBS). These services are paid for by DVA through arrangements that guarantee no out-of-pocket costs for eligible services that are accessed by holders of Gold and White cards. Other mental health treatment services are paid for by DVA via contracted arrangements with providers, such as private hospitals.

3.54 It also noted that former members of the ADF 'have access to services in the general community, including state/territory public health systems, broader public health initiatives and services provided by non-government organisations including ex-service organisations (ESOs), and post-traumatic stress disorder (PTSD) treatments services in the community'.[62] In November 2015, as part of its response to the NMHC report of mental health programs, the Australian Government announced a renewed approach to suicide prevention through the establishment of a new National Suicide Prevention Strategy. In particular, the strategy was being led by Primary Health Networks (PHNs) in partnership with local hospital networks, states and territories, and other local organisations with funding available through a flexible funding pool. On 28 May 2017, the Hon Greg Hunt MP, Minister for Health, announced a '$47 million boost to front-line services for suicide prevention and directly address a growing community need'.[63]

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61 NMHC report, p. 26.

62 NMHC report, p. 26.

63 The Hon Greg Hunt MP, Minister for Health, 'Providing $47 million for suicide prevention work across Australia', *Media release*, 28 May 2017.

Table – DVA overview of mental health expenditure in 2014-15[64]

Category	$m	Description
Private Hospitals	43.3	Contracts with private hospitals for the purchase of emergency, acute care and outpatient mental health services for the veteran community.
Public Hospitals	39.4	Arrangements with all state and territory governments. Public and private hospitals expenditure also includes 13 trauma recovery programs for posttraumatic stress disorder provided in hospitals around the country.
Psychiatrists	21.7	Provide psychiatric assessments, diagnoses, medicine management and clinical reviews as well as ongoing treatment.
Veterans and Veterans Families Counselling Service (VVCS)[1]	32.6	Counselling support and mental health treatment by psychologists and mental health accredited social workers. Includes case management services, group programs.
Pharmaceutical	17.2	Includes anti-depressants, psycho stimulants and dementia-related drugs.
Allied Mental Health Workers	5.4	Provide assessments and consultations, including group and individual therapies from professionals such as psychologists or social workers.
General Practitioners	23.1	Provide mental health assessment and access to treatment.
Australian Centre for Posttraumatic Mental Health (now Phoenix Australia)	1.4	Provides evidence based expert advice to inform and underpin DVA's policies and programs.
Mental health budget measures	3.1	Population measures including *At Ease* website; mobile phone applications; and provider engagement training and resources.
TOTAL	187.2	

Veterans and Veterans Families Counselling Service

3.55 In particular, DVA highlighted the work of the Veterans and Veterans Families Counselling Service (VVCS) as a frontline mental health service for the veteran community. VVCS provides a range of services including clinical support and

64 *Submission 156*, p. 6.

counselling options to veterans and their families who are experiencing service-related mental health and wellbeing conditions. DVA noted:

> In 2014-15, through its nation-wide network that includes 14 centres, a range of satellite centres, and more than one thousand contracted outreach clinicians, VVCS delivered 92,861 counselling sessions to 14,627 clients. An additional 5,350 clients had their concerns resolved at intake, 1,610 clients participated in group programs and 6,571 people received after hours support.[65]

3.56 In its mental health report in 2016, the committee recommended that eligibility requirements for VVCS be consolidated and broadened to include all current and former members of the ADF and their immediate families (partners, children, and carers). The Australian Government partly agreed to expand eligibility to VVCS to include all current and former permanent members of the ADF through White Card arrangements and to include certain family groups.[66] The 2017-18 budget included expansion of eligibility access to VVCS:

> Any partner, dependant or immediate family member will have access to the services and support provided by VVCS, including counselling and group programs. Former partners of ADF personnel will also be able to access VVCS up to five years after a couple separates or while co-parenting a child under the age of 18.[67]

Operation Life

3.57 DVA's Operation *Life* initiative aims to prevent suicide and promote mental health and resilience across the veteran community. It is intended to provide veterans and their families with the tools to recognise and act on suicidal tendencies in the early stages. It includes website resources, a companion app and workshops run by the VVCS to 'increase the ex-service community's awareness of, and ability to respond to, suicidal behaviour in individuals'. The VVCS workshops included;

- safeTALK (suicide alertness for everyone) – a half-day presentation;
- ASIST (Applied Suicide Intervention Skills Training) – 2-day skills training; and
- ASIST Tune-up (Applied Suicide Intervention Skills Training Tune-Up) – a half-day refresher workshop.[68]

3.58 DVA noted the 2016-17 Budget included $1 million over four years for the Veteran Suicide Awareness and Prevention Programs for the continuation of Operation *Life*.[69]

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65 *Submission 156*, pp 7-8.

66 Government response to Senate Foreign Affairs, Defence and Trade References Committee report, *Mental health of Australian Defence Force members and veterans*, September 2016, pp 10-11.

67 *Budget 2017-18, Portfolio Budget Statement, Budget Related Paper No. 1.4B*, p. 16.

68 *Submission 156*, p. 9.

Non-liability health care – mental health conditions

3.59 The Budget 2017-18 included funding of $33.5 million over four years to provide treatment for all mental health conditions under non-liability health care arrangements. This built on the previous initiative which allowed all current and former members of the ADF who had served one day in the full-time ADF to be able to access treatment for the specific common mental health conditions such as PTSD. The new initiative was expected to benefit around 2,000 current and former ADF members and would include coverage for adjustment disorders, acute stress disorder, phobias, panic disorder, agoraphobia, and bipolar and related disorders.[70]

> Treatment under the non-liability health care arrangements is delivered through the provision of a DVA White Card. Services available under these arrangements may include general practitioner, psychiatrist, psychologist, medication, public or private hospital, and counselling.[71]

3.60 DVA officials also noted that the expansion of non-liability health care had been well received. Mr Luke Brown, Assistant Secretary, Policy Support Branch from DVA told the committee that in the 2016 calendar year for non-liability health care for mental health conditions, DVA had 8,049 successful claims, which was a 55 per cent increase on last calendar year.[72] The estimated cost of mental health treatment used in the costing of the 2017-18 Budget measure to expand treatment to all mental health conditions under non-liability health care arrangements was $4,500 per patient per annum.[73]

Pilot studies

3.61 A number of pilot studies and programs related to suicide prevention have recently been announced. On 11 August 2016, the Australian Government announced a suicide prevention trial site would be established in North Queensland. Minister Tehan outlined:

> This will occur through the North Queensland Primary Health Network. As part of its work, the trial will focus on veterans' mental health. This will be one of 12 innovative, front-line trials in our fight against suicide which will improve understanding of the challenges and work to develop best-practice services which we can be applied nationwide.[74]

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69 *Submission 156*, p. 9.

70 DVA, 'Mental health treatment for current and former members of the Australian Defence Force – expanded access', *Budget 2017-18*, p. 1.

71 DVA, 'Mental health treatment for current and former members of the Australian Defence Force – expanded access', *Budget 2017-18*, p. 1.

72 *Committee Hansard*, 6 February 2017, p. 64.

73 DVA, response to question on notice 9, Budget estimates, 30 May 2017, p. 1.

74 The Hon Dan Tehan MP, Minister for Veterans' Affairs, 'Government supports veterans and ADF personnel', *Media release*, 11 August 2016.

3.62 The 2017-18 Budget included funding of $9.8 million over three years to pilot two new approaches to supporting vulnerable veterans experiencing mental health concerns. DVA stated:

> The two suicide prevention pilots announced in this year's Budget are specific mental health treatment interventions, which will support vulnerable veterans with complex acute or chronic mental health conditions. The first pilot, the Mental Health Clinical Management Pilot, will be delivered to an at-risk population with complex mental health needs on discharge from a mental health hospital. These participants will be at risk of self-harm, re-admission and/or homelessness. The second pilot, the Coordinated Veterans' Care (CVC) Mental Health Pilot, will be targeted at patients with chronic mental and physical health comorbidities, who require clinical management through general practice and, where necessary, other mental health professionals.[75]

3.63 Over the two years of the pilot programs, up to 100 veterans will participate in the Mental Health Clinical Management Pilot, and up to 250 veterans will participate in the expansion of the Coordinated Veterans' Care (CVC) program.[76] In relation to the CVC pilot, DVA provided information from an evaluation which indicated that 'although expected savings are yet to be achieved, there is evidence to suggest that these could arise with longer term program enrolments' and there were 'positive qualitative benefits' based on feedback by veterans and General Practitioners.[77]

Mental health assistance

3.64 Access to mental health services by veterans was perceived as a critical component in suicide prevention. Many submitters noted the relationship between incidence of mental illness and rates of suicide. In particular, they identified veterans with mental illness as being an 'at risk cohort'.[78] The AISRP noted:

> The Mental Health Prevalence and Wellbeing Study (MHPW) found that more than half of the ADF population sampled had experienced mental illness in their lifetime, significantly higher compared to the general population, despite the "healthy worker effect" (those selected into the military are screened for mental illness prior to entry, creating a more healthy population). In March 2015, DVA reported it was supporting 147,318 veterans, with 49,668 of these having accepted mental disorders.[79]

3.65 Phoenix Australia also observed that the 2010 MHPW study indicated that 90 per cent of those reporting suicidal ideation had a mental health condition. Accordingly, it considered it was important 'to address the quality of mental health

75 DVA, response to question on notice 10, Budget estimates, 30 May 2017, p. 1.

76 DVA, 'Suicide prevention pilots', *Budget 2017-18*, p. 1.

77 DVA, response to question on notice 15, Budget estimates, 30 May 2017, p. 1.

78 For example, VVFA, *Submission 277*, p. 8.

79 *Submission 174*, p. 2.

treatment available to veterans, and improve the service system that delivers treatment, in order to address this risk factor and reduce the rate of suicide'.[80]

Lack of expertise in treating veterans

3.66 It was highlighted that the ADF only employed one full-time psychiatrist at the ADF Centre for Mental Health.[81] Dr Jonathan Lane, a consultant psychiatrist, considered:

> This has the unfortunate consequence that there is not a body of clinicians who actually have a significant amount of experience working with the military, full stop, let alone working with veterans. There are no formal training pathways for military psychiatry or for dealing with veterans, so it is a very under-utilised and under-resourced area in the clinical expertise that clinicians have when they are dealing with veterans.
>
> I think this leads to the estrangement of veterans when they actually have left the military and when they are trying to access services in the civilian community.[82]

3.67 Dr Lane also noted that there was 'no training for psychiatrists during medical school or during your training period as a psychiatrist in military psychiatry or in veterans culture and community'.[83] Similarly, Dr Khoo observed that 'there are a lot of my colleagues who provide reports who would not have a clue about military medicine, military culture or what happens to a soldier after they are deployed and after they are discharged'.[84]

3.68 This point was also echoed by veterans and ESOs. For example, the William Kibby VC Veterans' Shed noted a previous proposal that 'both men and women exiting the ADF be offered placements at various universities around Australia, to study medicine, the view to branching to either studying Psychiatry or Psychology'. It stated:

> This idea was brought up because of the extreme shortage of both Psychiatrists and Psychologists with an ADF background.
>
> All too often we at the Veterans' Shed have heard the comments of "how would they know, they weren't there", which translated means how can someone without an operational experience treat someone who has seen operational service?[85]

3.69 Defence specific training for clinicians was available through online courses offered by DVA and training programs offered by the Phoenix Australia.[86] DVA

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80 *Submission 177*, p. 2.

81 *Committee Hansard*, 17 November 2016, p. 21.

82 *Committee Hansard*, 17 November 2016, p. 16.

83 *Committee Hansard*, 17 November 2016, p. 17.

84 *Committee Hansard*, 2 February 2017, p. 15.

85 *Submission 97*, p. 4.

86 For example, Dr Katelyn Kerr, *Committee Hansard*, 2 February 2017, p. 8.

noted there were six e-learning programs for mental health practitioners that were available through the *At Ease* portal. These were:

- vetAWARE;
- Understanding the Military Experience;
- Case Formulation;
- Working with Veterans with Mental Health Problems (GP specific);
- PTSD - Psychological Interventions Program; and
- the VVCS Practitioners Guide.[87]

3.70 In addition to these resources, DVA outlined that it 'provides a research dissemination website, known as Evidence Compass, an on line version of an assessment tool, *ADF Post-discharge GP Health Assessment,…Mental Health Advice Book and Beyond The Call: stories from veterans and their families'*.[88]

3.71 The Australian Psychological Society thought that the 'current DVA suite of eLearning online training such as 'understanding the military experience' modules are important in building a cohort of providers informed in the military experience'. However it noted:

> [T]here is no requirement for DVA providers to undertake this training and there are currently no incentives for health practitioners to complete the training. Additionally, there is no mechanism for referrers or consumers to identify service providers who have undertaken the DVA training.
>
> This gap could be remediated by (a) introducing enhanced comprehensive training for service providers delivering mental health services to this cohort; this could comprise a series of linked modules that include an assessment component and evidence of completion and would provide an indication of basic competencies (Practice Certificate), (b) implementing a system for identifying who has undertaken the training, and (c) introducing incentives for undertaking the training and demonstrating outcomes in clinical practice.[89]

3.72 Similarly, Mates4Mates argued that '[c]linicians who treat veterans need to also have astrong understanding of the military context from which the veteran has originated'. It suggested:

> To instill confidence in veterans it would be useful if there was a way for them to know which provider has completed the DVA training modules. This will provide veterans with a level of confidence that these service providers have an understanding of their unique situation – this will help

87 *Submission 156*, p. 11.

88 *Submission 156*, p. 11.

89 *Submission 42*, p. 1.

> with the development of a strong therapeutic relationship and means the veteran will hopefully be in a better position to continue to seek support.[90]

3.73 The AISRP commented that '[w]orking with current and ex-serving members requires a unique and specialised skill set incorporating intimate knowledge of their work experiences, demands, organisational culture, and traumas'. Many mental health clinicians feel under-skilled or unprepared for working with veterans, and therefore choose not to see this client group. It observed:

> DVA provides online training to up-skill practitioners, however there are no incentives for clinicians to undertake this training, and eLearning only suits those comfortable with that learning style. DVA could introduce face-to-face training for clinicians to increase confidence and skills and provide remuneration for this, which would increase the number of experienced and high quality professionals working with veterans.[91]

3.74 The NMHC report recommended further enhancement of specialist mental health expertise within the ADF. This could include 'a greater number of military psychiatrists, engagement of mental health nurse practitioners, and more allied health practitioners with clinical mental health expertise'. The NMHC suggested the cost of this enhancement could be off-set by reducing outsourced mental health specialist services.[92] In relation to this issue, Defence emphasised that the Defence White Paper included engagement of additional permanent ADF specialist mental health personnel:

> This initiative will expand the Medical Specialist Program to include the specialty of psychiatry through an additional seven specialist psychiatrist or trainee registrar positions. This will form the core of ongoing reform of delivery of specialist mental health services to deployable, deployed and returned ADF personnel.[93]

3.75 The NMHC also proposed that consideration be given to 'funding and developing further specialist mental health centres of excellence within all major defence service regions, providing local capability and knowledge as well as the opportunity to form partnerships and build the evidence base through high quality research and service evaluation'. It stated:

> Such centres would see consultant psychiatrists working within specialist multi-disciplinary teams which include mental health nurses, allied health practitioners and peer workers, and could potentially offer services to current and former serving personnel, and their families.[94]

3.76 The Australian Government response noted that 'Defence has a number of current actions in place to expand specialist mental health expertise within Defence

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90 *Submission 173*, p. 2.

91 *Submission 174*, p. 3.

92 NMHC report, p. 54.

93 *Submission 124*, p. 15.

94 NMHC report, p. 54.

Health Services supported by an expansion of the role of the ADF Centre for Mental Health'. It stated:

> Defence has a proposal to expand the existing ADF Centre for Mental Health as the centre of excellence within Defence, to create a bespoke model for supporting access to clinical expertise across Defence regional health services and develop partnerships with other external national centres of excellence.
>
> As part of the 2016 Election commitments, the Government committed to providing $6 million over four years from 2016-17 to develop the Centenary of Anzac Centre in partnership with Phoenix Australia. The Centre will perform two primary functions, of providing practitioner support and treatment research.[95]

Fees

3.77 During the inquiry into the mental health of ADF serving personnel, the committee raised concerns regarding the evidence that psychologists are unwilling or unable to treat veterans due to DVA providing inadequate funding for psychological services. The committee noted that there is a significant gap between the DVA schedule of fees and the Australian Psychological Society's schedule of recommended fees. The committee raised concerns that inadequate funding of psychological services would limit the already scarce mental health services available to veterans (especially those living in regional or remote areas).

3.78 The committee recommended that the DVA Psychologists Schedule of Fees be revised to better reflect the Australian Psychological Societies' National Schedule of Recommended Fees, and that any restrictions regarding the number of hours or frequency of psychologist sessions are based on achieving the best outcome and guaranteeing the safety of the veteran.[96]

3.79 These concerns during the gaps in fees paid by DVA and access to specialist care were repeated during the current inquiry. The Australian Psychological Society commented:

> At the present time, there is a freeze on the DVA Psychology Schedule of Fees. This freeze dates back to 2014 and acts as a disincentive for the uptake of skilled clinicians. Unlike other existing mental health services for civilians (e.g. Better Access to Psychiatrists, Psychologists and General Practitioners through the MBS initiative), there is no capacity to charge a co-payment for DVA services. This inability to strike a fee that reflects the practitioner's expertise and the typically complex needs of ex-serving personnel and veterans is an operational disincentive to the uptake of such work by practitioners who would otherwise be willing and suited to it.[97]

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95 Government response to the NMHC report, p. 70.

96 Senate Foreign Affairs, Defence and Trade References Committee, *Mental health of Australian Defence Force members and veterans*, March 2016, p. 90.

97 *Submission 42*, p. 2.

3.80 The AISRP also commented on this 'large discrepancy' between the fee charged to private civilian clients and 'that which DVA pays; which was creating a disincentive for experienced and skilled clinicians to see veterans:

> If DVA would match the fee schedule provided by Medibank Health Solutions or that recommended by the APS, this would increase the number of psychologists willing to see veterans and would increase the delivery of gold-standard interventions which have high success rates in treating mental disorders. Many veterans report receiving pharmacological treatment, but are not receiving psychological treatment which is the gold-standard because it is highly effective in creating many disorders commonly experienced by veterans (eg. PTSD, depression, anxiety, substance use disorders).[98]

3.81 When questioned on this issue, Ms Sue Campion, First Assistant Secretary, Health and Community Services with DVA stated:

> The difference is that generally our health services are based on the MBS and PBS and other things, and then we add to them. So in the case of the MBS and fees, we pay the MBS fee plus an additional percentage to reflect the fact that our fees represent the full payment for service, so there is no patient contribution. Defence's model is that they have purchased the provision of health services through, in this current instance, Medibank, but they are not referencing necessarily to the MBS rates. They have negotiated a separate contract for the provision of their services, whereas we rely on the general universal access health system and then add to it.[99]

3.82 DVA acknowledged evidence provided to the committee about psychiatrists and psychologists not accepting DVA fee arrangements or withdrawing from these arrangements. However, it considered it was not possible 'to discern trends from the data about the extent of provider participation in DVA arrangements'.[100] It stated:

> In the event that a practitioner may not accept DVA fees or there are no providers, DVA provides assistance in identifying another suitable practitioner, providing transport assistance, or considering a provider's request to fund services above DVA fees. An 'above fee' request is determined on the basis of clinical need, and includes consideration of the patient's ability to reasonably access another suitable practitioner. [101]

3.83 DVA argued it was not possible to directly compare Defence fees with those of DVA. It noted that on base health services provided to currently serving members 'are delivered by a mixed workforce of ADF, APS and contractors, inclusive of mental health professionals'. The on-base contractor health workforce is provided under the contract with Medibank Health Solutions. In contrast, DVA arrangements for medical

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98 *Submission 174*, p. 4.

99 *Committee Hansard*, 6 February 2017, p. 61.

100 DVA, response to question on notice from hearing 6 February 2017.

101 DVA, response to question on notice from hearing 6 February 2017.

services, including psychiatry are aligned to Medicare although it highlighted that DVA fees are set at a higher rate than comparable Medicare fees.[102] It outlined:

> DVA psychiatry consultations are paid at 135 percent of the equivalent Medicare fee, with a psychiatrist consultation of between 45 minutes and 75 minutes currently $247.95 under DVA and rebated under Medicare at $156.15 (which is 85 per cent of the Medicare fee).
>
> In 2010 when DVA introduced individual fee schedules for each allied mental health profession, the fees reflected the MBS-equivalent time based items and were paid at 100% of the MBS rate, as part of a package negotiated with the relevant provider associations at the time.
>
> Under current DVA arrangements for clinical psychology, a consultation lasting 50 minutes or more attracts a fee of $148.95 where the equivalent is rebated under Medicare for $124.50 (which is 85 percent of the Medicare fee of $146.45). The indexation of the DVA fees has been paused since November 2014, with the pause to continue until 30 June 2018.[103]

Model of care

3.84 The most effective model for mental health services to support veterans and the need for veteran-specific services was also discussed during the inquiry. The relevance of this issue was illustrated by the planned closure of the Repatriation General Hospital in Adelaide at the end of 2017 and the movement of services to the Jamie Larcombe Centre at Glenside Health Service Campus. The South Australian Government outlined that this new $15 million facility was intended to be a '[post-traumatic stress] Centre of Excellence in recognition of the potential impact of military service on the mental health of service and ex-service personnel':

> The new facility will be purpose built and will incorporate an acute 24 bed inpatient unit, outpatient services, teaching and research spaces…It is envisaged that the Precinct will provide comprehensive, trusted and person centred, family orientated veteran mental health services.
>
> In the context of the new Veterans Mental Health Precinct, it has been timely to review the Model of Care for specialist mental health services for veterans. Clinicians, managers, consumers, carers and emergency service personnel are engaging in the process and contributing to the Model of Care that will incorporate innovation, is shaped by evidence based practice, and defined by standards of care to address the mental health care needs of veterans and emergency service personnel. Research is seen as a critical element to ensure the Model of Care is flexible and able to identify the most appropriate treatment options.[104]

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102 DVA, response to question on notice from hearing 6 February 2017.

103 DVA, response to question on notice from hearing 6 February 2017.

104 *Submission 187*, pp 3-4.

3.85 There were perceived advantages in services for veterans being co-located and veterans being able to receive treatment together. For example, Mr Guy Bowering told the committee about his experiences in Ward 17 at the Repatriation General Hospital:

> The crash and burn of my PTSD experience within the Repatriation General Hospital also allowed my other comorbidities to be taken care of all in one place. No-one I met within Ward 17 had just PTSD; they had things like sleep problems, gastrointestinal problems, diabetes, chronic pain et cetera. All these were taken care of on one site…Military and veteran mental health is not a cookie-cutter version of a normal mental health facility. It acknowledges the peculiar service and stresses that we put on our military members, and the treatment is tailored with that in mind. Ward 17 cannot exist as a standalone facility. It requires the support of facilities that only a hospital campus like the Repatriation General Hospital can supply. With the move, current ADF members and veterans will receive a degraded service.[105]

3.86 RANZCP noted that as specialist services, veteran hospitals provide a number of advantages. These included:

- specialist staff across a range of health domains, including psychiatry, representing consolidated clinical knowledge passed down through generations of specialist training and 'on-the-job' experience;
- evolving models of care attendant to changing needs based on clinical observation and assessment, consolidation of knowledge and innovation of services;
- assured service provision with continuity of care; and
- improved advocacy and understanding of system deficiencies facilitated by structured communication lines between veterans and community members, health professionals and departmental management.

3.87 The RANZCP commented that without the concentration of expertise engendered by a system of veteran-specific hospitals, health care is provided to veterans according to the purchaser-provider model, requiring them to source their own service. It noted this could lead to fragmented services offering models of care at varying levels of quality with no guaranteed continuity of care. It was aware of veterans which had found sourcing of appropriate care difficult.[106]

3.88 The RSL observed that the purchaser provider model is 'very much focused on the provision of funding for consultations and episodes of care'.

> It takes little overarching analysis of the different requirements of patients with different levels of acuity. There needs to be a system that has secondary and tertiary referral services for those who are not responding to the primary evidence-based treatments. The access to the higher acuity levels of care for veterans needs to be audited.

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105 *Committee Hansard*, 17 November 2016, p. 39.

106 *Submission 156*, p. 10.

> As veterans hospitals substantially no longer exist, the priority care for veterans is more difficult to deliver. Much of the care, particularly when the very unwell, is now provided within the state systems. We know that these are underfunded and often individuals who represent a significant suicide risk are turned away. They have little expertise in trauma-related psychopathology and are not likely to deal well with the types of needs a veteran is likely to present.[107]

3.89 Another key concern was enabling choice by veterans in relation to mental health services. For example, DefenceCare RSL considered that DVA's services were 'prescriptive and based on clinical-only treatment' leaving veterans with 'little say in the allocation of funding to clinical or non-clinical treatments or aids that they believe are important to their particular circumstances'. It recommended investigation and a trial of a model of consumer directed care (CDC) for veterans:

> CDC empowers the consumer to have more control over their life and be in charge of decisions about their lifestyle and support. It focuses on the person's life goals and strengths, placing their needs at the centre of the services and support. The person makes choices and/or manages the services they access, to the extent they can and wish to do so, including who will deliver services and when.[108]

3.90 The Australian Psychological Society commended DVA's work over the last decade to review and improve 'the range of funded inpatient, outpatient, teleconferencing and online services for veterans'. However, it noted that there was evidence that 'current service models do not effectively reach a large number of veterans' and this particularly disadvantaged veterans in rural and remote areas and veterans with physical disabilities. It suggested a 'hub and spoke model of service delivery could improve access for many of these veterans'. It stated:

3.91 The NMHC report advised Defence and DVA to 'continue to build on the stepped mental health care model in place and ensure that a range of early intervention options are available that can maximise early help-seeking and minimise the impact that mental illness may have (e.g. on career progression or deployment or post-military employment)'.[109] The Government's response to the NMHC report noted that the Department of Health through primary health networks and national programs was increasing the availability of low intensity services including digital services which would be able to support both current and former members of the ADF. In particular, these digital services, including the $30M investment in the Synergy IT, would respond to 'the help-seeking behaviours of at-risk young men'.[110]

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107 *Submission 216*, p. 2.

108 *Submission 216*, pp 17-18.

109 NMHC report, p. 53.

110 Government response to NMHC report, p. 70.

Conclusion and recommendations

3.92 Suicide by veterans is particularly disturbing due to a recognised collective responsibility for the welfare of those who have rendered service on behalf of the community. Further, ADF members are a healthy and resilient group, who benefit from high-quality support while in uniform. In this context, there are understandable concerns that the suicide rate for the veteran community is not significantly lower than the general population.

3.93 The reasons why a person may decide to take their own life can be very complex. In particular, not everyone who has suicidal ideation has a mental health condition. The evidence received covered a range of factors which might contribute to veterans and ex-service personnel taking their own lives. Research in this area is still continuing and at this stage it is difficult to discern any clear trend or common factor. To the committee, this indicates that the current preventative, early intervention model targeted to those at risk, together with a holistic response to improve the overall welfare of veterans is the most appropriate approach to reduce the rate of suicide amongst veterans.

3.94 The NMHC report recommended addressing the needs of younger veterans following the release of the first AIHW results which identified this cohort as a vulnerable group. The NMHC urged 'as a matter of priority' that the Minister of Veterans' Affairs liaise with the Minister for Health 'to oversee the development of strategies, utilising a co-design process, to engage and support former members of the ADF aged 18-29 years, who have left the service in the last 5 years and who could be at risk of suicide or self-harm'.[111] The Government response outlined several initiatives directed to this age group. These included:

> The Government recently allocated $30 million to develop digital mental health initiatives as part of Project Synergy, including an internet-based platform for mental health tools primarily targeted at young people. As part of this investment, a trial with VVCS clients will be conducted…
>
> The Australian Government funds the headspace network, which provides free or low cost access to youth specific mental health services for young people aged 12-25 years. headspace services are also available to young veterans, defence personnel and their families across Australia. headspace takes a holistic approach to mental health by also providing support for related physical health, drug and alcohol problems, and social and vocational support. Where headspace is not the best service for a young person, headspace will use established clinical pathways to connect young people to appropriate services.
>
> Government is partnering with Lifeline Australia to support the $2.5 million trial of a new crisis text service, Text4Good, for all Australians in need.[112]

111 NMHC report, p. 53.

112 Government response to NMHC report, p. 68.

3.95 In the view of the committee, there is more that can be done to respond to these new research findings. The recent AIHW research findings concerning at risk groups based on their age, discharge and service characteristics should be used to develop new targeted suicide prevention and veteran support programs. Additional targeted programs to these at-risk veterans could yield long-term improvements in the health and welfare outcomes as well as contributing to reducing the incidence of suicide and self-harm.

3.96 In particular, DVA has already outlined to the committee the positive results achieved by the *DVA Reconnects* project which aims to reconnect with clients through proactive contact attempts and the provision of a complex and multiple needs assessment.[113] DVA (with the assistance of with Defence) should be matching the information they have about recent veterans with these identified 'at-risk' characteristics. Where DVA identifies veterans who have these at-risk characteristics, DVA should be proactively seeking to contact these veterans to ensure that they are aware of the supports available to them.

Recommendation 1

3.97 The committee recommends, that in the context of recent Australian Institute of Health and Welfare findings concerning veterans at risk of suicide, the Australian Government:

- **develop and implement specific suicide prevention programs targeted at those veterans identified in at-risk groups; and**
- **expand the DVA Reconnects Project to proactively contact veterans in these identified in at-risk groups.**

3.98 A large number of submissions from veterans focussed on the issues confronting them due to the complex legislative framework of veterans' entitlements and its administration by DVA. Problems with the compensation claims process were often perceived as key stressors and contributing factors to suicide by some veterans. Further consideration of improvements in these areas will be addressed in the next chapters. However, in the view of the committee, there is a lack of research in this specific area. In particular, the impact of DVA claim assessment processes as a stressor on veterans and their families.[114] On the evidence received, the committee considers this topic merits an independent investigation. The results of this study should be used to improve and restructure DVA assessment processes to reduce the stress for veterans and improve overall outcomes.

Recommendation 2

3.99 The committee recommends that the Australian Government commission an independent study into the mental health impacts of compensation claim assessment processes on veterans engaging with the Department of Veterans'

113 *Submission 156*, p. 15. See discussion in Chapter 6.

114 For example, Dr Katelyn Kerr, *Committee Hansard*, 2 February 2017, p. 3.

Affairs and the Commonwealth Superannuation Corporation. The results of this research should be utilised to improve compensation claim processes.

3.100 The committee welcomes the valuable investment of DVA and Defence in the Transition and Wellbeing Research Programme and other research initiatives. The AISRP report has highlighted that research into veteran suicide carried out in other countries cannot necessarily be applied to Australia. Further, ongoing research will be needed. The committee notes that DVA and Defence are currently in discussions with AIHW to continue and regularly update its work on the incidence of veteran suicide. Building on this recent valuable study, there needs to be consideration regarding the establishment of a permanent National Veteran Suicide Register based on the model of the Queensland Suicide Register (QSR).

3.101 The QSR works with police and the coronial system to gather more detailed data on deaths by suicide that occur in that jurisdiction. While the broad direction of the suicide rate amongst veterans will be useful in determining the extent of the issue and to track change, there is a range of other significant information that could be collected to inform policy approaches in the future. The creation of an official publicly funded register may also serve to allay concerns raised that unofficial registers could sensationalise the topic of veteran suicide and have other negative consequences.

Recommendation 3

3.102 The committee recommends that the Australian Government establish a National Veteran Suicide Register to be maintained by the Australian Institute of Health and Welfare.

3.103 The committee was concerned by evidence regarding a lack of psychiatric expertise within Defence. However, Defence has indicated it is improving mental health care and support for ADF members, including through the 'engagement of an additional six specialist psychiatric trainees and specialists as well as one administrative coordinator'.[115] The lack of experience in treating veteran-specific issues within the Australian professional mental health community was also troubling. The Australian Psychological Society made a number of proposals to enhance the online training to practitioners provided of DVA. In the view of the committee, these proposals deserve departmental consideration.

Recommendation 4

3.104 The committee recommends that the Australian Government review the enhancement of veteran-specific online training programs intended for mental health professionals. In particular:

- **requirements for providers to undertake training;**
- **the introduction of incentives for undertaking online training and demonstrating outcomes in clinical practice.**

115 Government response to the NMHC report, p. 15.

3.105 The committee was concerned that discrepancies between the fees paid by Defence and DVA continue to be identified as a barrier to veterans accessing professional mental health services. In order to ensure seamless care is provided to both serving ADF members and veterans, the committee considers that these arrangements for the provision of mental health care should be aligned. In particular, there should be no difference in the fee paid to a mental health professional by Defence or DVA regardless of whether the patient is a serving ADF member or a veteran.

Recommendation 5

3.106 The committee recommends that Defence and the Department of Veterans' Affairs align arrangements for the provision of professional mental health care.

3.107 During the inquiry, committee members expressed concern with the progress of the suicide prevention trial for Townsville. In May 2017, it was announced that a Veteran Suicide Prevention Project Manager had been appointed.[116] While the committee understands this project is being led the North Queensland Primary Health Network, the committee urges the Australian Government to work to expedite implementation and assessment of this trial which has the potential to be an important model for support services in other parts of Australia.

116 Northern Queensland Primary Health Network, 'Townsville veteran suicide role appointed', Media release, 9 May 2017, available at https://www.votsa.org.au/images/News/NQPHN/NQPHN_Media_Release.pdf (accessed 17 July 2017).

Chapter 4
Legislative framework

Introduction

4.1 Many of the complaints made regarding the current system of compensation and rehabilitation for veterans are related to the overall legislative framework. In this context, this chapter will cover discussion concerning:

- previous reviews of compensation arrangements;
- recent proposed legislative reform;
- key compensation issues;
- issues concerning complexity and inconsistency;
- support for a large scale review; and
- issues raised regarding the role of the Repatriation Medical Authority (RMA) and application of the Statements of Principles (SoPs).

Previous reviews of military compensation arrangements

4.2 DVA noted that Australia's military compensation arrangements have been regularly reviewed and updated since their introduction prior to the First World War. It listed 12 major reviews of compensation arrangements between 1975 and 2000.[1] In particular, *A Fair Go: Report on Compensation for Veterans and War Widows* undertaken by Professor Peter Baume (Baume review) in 1994 led to significant changes. DVA highlighted findings of three previous reviews:

- the Review of the Military Compensation Scheme (Tanzer review) in 1999;
- the Review of Veterans' Entitlements (Clarke review) in 2003; and
- the Review of Military Compensation Arrangements (MRCA review) in 2011.

4.3 The findings of the *Independent Study into Suicide in the Ex-Service Community* by Professor David Dunt (Dunt review) in 2009 are also relevant.

Baume review

4.4 The Baume review followed an Auditor-General report which criticised compensation arrangements for veterans and their families and a decision of the High Court in *Bushell v Repatriation* (1992) 175 CLR 408 which impacted the way in which medical evidence was required to link a disease or disability with war service.[2] The Baume review believed that the *Bushell* decision would have 'a significant effect on the acceptance rates of claims, both in the first instance, and on appeal'. It noted that the standard of proof used was unique to the veterans' jurisdiction but characterised it as 'confusing and complex to apply', 'subject to

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1 DVA, *Submission 156*, p. 32.

2 Baume review, p. 1.

wide interpretation', 'excessively generous' and 'offers potential for exploitation through "doctor shopping"'.[3]

4.5 After weighing alternative options, the Baume review recommended the standard of proof should be changed to 'one which is fair and generous, while consistent in its application and legally unambiguous'. It recommended that 'the standard on proof be based on the legally accepted "civil standard" with the provision that the benefit of doubt be in the favour of veterans with operational service'.[4] It noted:

> The intention of this amendment is to move away completely from the inappropriate and confusing reverse criminal standard with the reasonable hypothesis test. The aim is to use a test which already is well tested but make it more beneficial than usual.[5]

4.6 The Baume review also recommended that an independent expert medical committee be established to resolve general medical issues and to formulate statements of principle for application to all decision-making.[6] The Australian Government did not accept the Baume review's recommendation and retained the concepts of 'reasonable hypothesis' and the reverse onus of proof to the criminal standard. However, the Baume review led to the introduction of Statements of Principles (SoPs) and the establishment of the Repatriation Medical Authority and the Specialist Medical Review Council (SMRC).[7]

Tanzer review

4.7 The Tanzer review arose from issues relating to compensation differences between the VEA and SRCA following the Black Hawk crash in Townville in June 1996. The Tanzer review concluded that it would inappropriate to attempt to amend the VEA and SRCA and considered that there should be new scheme. It suggested 'a single self-contained military compensation scheme for peacetime service which recognises the different nature of military service from civilian employment'.[8] The recommendations of the Tanzer review led to the enactment of a new military compensation scheme under the MRCA in 2004.

Clarke review

4.8 As the MRCA was being developed, the Clarke review was established in 2002 to examine perceived anomalies in access to veterans' entitlements and of levels of benefits available to disability pensioners. It observed that '[a]lthough many legislative measures were consolidated with the passage into law of the VEA

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3 Baume review, p. 13.

4 Baume review, p. 13.

5 Baume review, p. 25.

6 Baume review, p. 13.

7 Professor Dennis Pearce, *Review of the Repatriation Medical Authority and Specialist Medical Review Council*, 1997, p. iii.

8 Tanzer review, p. 5.

in 1986, the eligibility provisions remain complex and partly reflect historical concepts that are difficult to apply'.[9] The review's report in 2003 made 109 recommendations relating to the extension of coverage under the VEA, changes to the disability compensation pension structure and the establishment of an integrated and comprehensive rehabilitation program.[10]

Dunt review

4.9 As noted above, an independent study into suicide in the ex-service community was undertaken by Professor David Dunt. The terms of reference of the study included 'highlighting changes in current policies, procedures and practices that exist in DVA that would minimise potential stress'. The Dunt review commented:

> It is widely recognised that the three military compensation schemes – Veterans' Entitlement Act (VEA), Safety Rehabilitation and Compensation Act (SRCA) and Military Rehabilitation and Compensation Act (MRCA) - are difficult for veterans to navigate and DVA delegates to advise and process. They also have differing aims - VEA is essentially a military compensation scheme, SRCA a worker's compensation scheme oriented to rehabilitation and MRCA has features of both…It would simplify the scheme considerably if the three acts could be rolled-up into one successor Act. It is worth noting that Canada and US have one scheme only and the UK one past and present scheme operating.[11]

4.10 The Dunt study review observed that 'the operation of MRCA and veterans' compensation more generally will be reviewed in 2009' and the report did not include a recommendation on this matter. The report acknowledged 'it is also not clear if it is possible to roll-up VEA, SRCA, MRCA into a successor scheme so that only one scheme exists and again do this without detriment to the existing benefits that a veteran would otherwise be entitled to obtain under existing arrangements'.[12]

MRCA review

4.11 The MRCA review was conducted by a steering committee chaired by the then Secretary of DVA, Mr Ian Campbell PSM. DVA noted that MRCA review had broad terms of reference which included 'the examination of the performance of DVA in relation to the operation of the MRCA, review of the size of benefits payable for death and serious injury under the MRCA' and an analysis of any anomalies that existed between the MRCA and other veterans entitlements.[13]

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9 Clarke review, p. 5.

10 *Submission 156*, p. 33.

11 Dunt review, p. 12.

12 Dunt review, p. 85.

13 *Submission 156*, p. 35.

4.12 The MRCA review produced its report in March 2011. It concluded that the objectives of the MRCA were sound and that the unique nature of military service justified rehabilitation and compensation arrangements specific to the needs of the military. It also made a large number of recommendations concerning opportunities for improvements. Accepted recommendations have been progressively implemented and the MRCA Review was formally closed with ministerial approval in September 2016.[14]

4.13 DVA emphasised that the MRCA review steering committee 'considered the complexities which exist for clients who have eligibility across two or three Acts and acknowledged that reducing the amount of military compensation legislation would be highly desirable':

> However, the Steering Committee also confirmed that consolidating entitlements into one Act would require the resolution of several complex, sensitive and potentially controversial issues.
>
> Apart from the different entitlements under the three Acts, other reasons why there is no simple, singular approach to address or fix the current complexities include:
>
> - there are accrued rights issues in changing entitlements once they have been accrued through periods of service;
> - complex transitional arrangements would be needed to protect existing entitlements and ensure no detriment to individuals; and
> - uniform compensation benefits could be seen as inconsistent with the nature of military service, and would imply, or could be interpreted to mean, that all military service is the same.
>
> Given the complexity of these legislative issues, the MRCA Review recommended that DVA concentrate on continuing to simplify the claims process for potential claimants.[15]

Recent proposed legislative reform

4.14 The Parliament is currently considering the Safety, Rehabilitation and Compensation Legislation Amendment (Defence Force) Bill 2016. This bill will duplicate the existing SRCA as a standalone act, with appropriate amendments to give full control of the act to the Minister for Veterans' Affairs. The standalone act created by the bill will be titled the Safety, Rehabilitation and Compensation (Defence-related Claims) Act 1988 (DRCA).

4.15 DVA has noted that the DRCA was being created by the bill to 'enable the Minister for Veterans' Affairs to solely administer all legislation relating to veterans' entitlements [allowing] the recognition of the unique nature of military service that may not be appropriate for civilians under the SRCA'. This would

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14 *Submission 156*, p. 37.

15 *Submission 156*, p. 30.

allow the Minister for Veterans' Affairs 'opportunities to start examining streamlining, simplification and alignment of legislation'.[16]

4.16 On 9 February 2017, the Senate referred the provisions of the Safety, Rehabilitation and Compensation Legislation Amendment (Defence Force) Bill 2016 to the Senate Foreign Affairs, Defence and Trade Legislation Committee for inquiry and report by 20 March 2017. The committee considered that the amendments would be 'a positive change to ensure that all three of the main legislative compensation and rehabilitation schemes for ADF members, veterans and their dependents can be responsive to the unique nature of military service'. This would facilitate 'reform to simplify and harmonise the legislative schemes, departmental practices and the claims processes for ADF members and veterans'.[17]

Key issues concerning compensation arrangements

4.17 DVA characterised establishing appropriate compensation levels for veterans as 'a fine balance of a number of principles'. It listed these principles as:

- meeting the needs and expectations of veterans and their families;
- recognition of the unique nature of military service;
- meeting community expectations of support and care for veterans and their families;
- ensuring modern approaches to rehabilitation and compensation;
- recognition of other Australian government compensation payments; and
- responsible economic management.[18]

4.18 DVA acknowledged that a '[c]omparison of compensation levels across the three Acts is not simple as there are different forms of compensation and other support structures, eligibility rules, assessment methods and scales of compensation in each Act'. It stated:

> Compensation provided under each Act cannot be considered in isolation. Each Act has different thresholds and other complementary benefits that must be taken into consideration to make an accurate comparison. The compensation provided must be considered in terms of the total benefits that are available.[19]

4.19 In this context, Mr Craig Orme from DVA highlighted the important role of the Commonwealth Superannuation Corporation (CSC) and access to invalidity class A, class B and class C benefits:

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16 Ms Carolyn Spiers, *Committee Hansard*, 15 March 2017, pp 25-26.

17 Senate Foreign Affairs, Defence and Trade Legislation Committee, *Safety, Rehabilitation and Compensation Legislation Amendment (Defence Force) Bill 2016 [Provisions]*, March 2017, p. 17.

18 *Submission 156*, p. 32.

19 *Submission 156*, p. 32.

If a member is medically discharged, the first assessment that is made on discharge, or prior to discharge, is the determination under the [CSC], which is effectively the insurance scheme covering ADF employment, which is not about liability but simply about the capacity of the individual to work. If a member is injured outside of work hours in a private capacity, they may not be covered under the [MRCA]. They are covered, however, by the [CSC]. If they are medically discharged, if their invalidity or impairment to work is assessed at 60 per cent or higher they are given an invalidity class A pension; if it is 30 to 59 per cent there is an invalidity class B pension, and below that there is a capability to work and access to certain superannuation benefits.[20]

4.20 In comparison to public servants covered by SRCA, Ms Carolyn Spiers, Principal Legal Adviser, DVA observed:

The rates payable for permanent impairment under MRCA are higher than that under SRCA. There are things like the Gold Card available under MRCA that are not available under SRCA. There is the safety net of the SRDP pension under MRCA that is not under SRCA.[21]

4.21 DVA provided a table of indicative compensation outcomes for a member of the ADF with paraplegia related to service under MRCA compared to indicative compensation outcomes for a public servant with a work related injury that results in paraplegia under the SCRA.[22]

Table – indicative compensation outcomes

	MRCA	SRCA
Permanent Impairment	96 impairment points (IP) under the Guide to Determining Impairment and Compensation - $335.73 weekly amount (including maximum lifestyle effects). This can be converted to a partial or total lump sum. **Total lump sum $448,971.73** Plus; • 80 or more IP – additional compensation of $86,429.75 for any dependent children along with a gold health care card and access to MRCAETS education assistance per child. • 60 or more IP – automatic entitlement to Gold Card (see below). • 50 or more IP – consideration for Special Rate Disability Pension (SRDP; see below). • Eligibility for financial and legal advice up to $2,549.31 each.	99% WPI whole person impairment under the Comcare Guide to the Assessment of the Degree of Permanent Impairment - $181,204.49. Plus maximum non-economic loss (NEL) - $68,638.10. **Total PI lump sum $249,842.59**

20 *Committee Hansard*, 6 February 2017, p. 56.

21 *Committee Hansard*, 6 February 2017, p. 53.

22 DVA, response to question on notice from hearing 6 February 2017.

4.22 The DVA submission also provided the following summary of entitlements for veterans and their dependents (as at October 2016).[23]

Table – Summary of entitlements for veterans and dependents

	Military Rehabilitation and Compensation Act 2004		*Safety, Rehabilitation and Compensation Act 1988*	*Veterans' Entitlements Act 1986*
	Periodic	**Lump Sum**	**Lump Sum**	**Periodic**
Compensation for permanent impairment	$335.73 (pw) (maximum)	$448,971.73 (maximum aged based conversion) $86,429.76 (Additional compensation in respect of each dependent child for persons assessed at 80+ impairment points)	$251,672.94 $78,235.87 (*Defence Act 1903* additional compensation for severely injured) $85,750.21 (Additional compensation for each dependent child)	Disability pension for life, with the rate depending on the degree of incapacity Rates $pw Special 673.45 Intermediate 457.20 EDA 372.00 General (10% to 100%) 27.40 – 239.40 (incl energy supplement)
Incapacity Payments	100% of normal earnings reducing to 75% after 45 weeks		100% of normal earnings reducing to 75% after 45 weeks. These amounts are both less 5% notional superannuation contributions.	Clients may be eligible for Loss of Earnings Allowance which tops up the disability pension
Compensation after Death – Widow(er)	$445.65 (pw)	$753,193.07 (maximum aged based conversion) $144,049.60 (Additional compensation where the death is service-caused)	$528,433.70 (shared with child dependants, if any) $58,339.81 (Defence Act 1903 additional compensation) $85,750.21 (Defence Act 1903 dependent child benefit)	$445.65 (pw) Up to $131.55 (pw) (means tested Income Support Supplement)
Compensation after Death – Dependent Child	$143.75 (pw) (while younger than 16 years- or from 16-24 years if in full-time education)	$86,429.75	$528,433.70 (shared with all dependents including widow(er). $145.32 (pw) (while younger than 16 years- or from 16-24 years if in full-time education)	Pension if war/service caused death of parent – conditions apply if child is older than 16 years eg not eligible if receiving education benefits. $49.60 (pw) if one parent deceased $99.10 (pw) if both parents deceased
Funeral Expenses	$11,654.06		$11,654.06	$2,000

23 Note: veterans' pensions were altered from 20 March 2017 following the latest round of indexation adjustments.

4.23 A range of views concerning compensation for veterans were raised during the inquiry. For example, Mr Peter Reece, a former DVA official, described the Australian system of military compensation as 'without doubt the most generous in the world – not just for the quantums available, but for the ease of access'. He considered the current system was 'more generous than any scheme for civilians, and for other like careers such as police forces and paramedics'.[24]

4.24 Mr Reece argued that implementing an appropriate system of income support for veterans should be the direction of reform rather than overreliance on the compensation system to deliver income support. He noted that '[c]ompensation is there to give people redress for actual, substantial losses in their income earning capacity and their career prospects and for the degree of suffering and physical shortfalls that they have to endure—it is not an income support policy'.[25] He told the committee:

> The system is designed for benefits that are in finality. Access to their disability under their superannuation, to Centrelink benefits, and all the rest of it is a complete mess. They are administered by different authorities with different regulations and rules. These people are pushed around from one to the other, and they come back to compensation because it is the only thing that people know and understand—particularly in the ex-service organisations.[26]

4.25 The RSL also raised issues about the appropriate balance between compensation, rehabilitation and healthcare in the current arrangements:

> A question that is rarely asked is whether this time, effort and cost results in the best benefit to the veteran concerned? In other words is the award of monetary compensation the optimum outcome or, might something else, rather than a compensation payment, such as comprehensive lifetime health care (i.e. the issue of a gold card) be more appropriate in some circumstances?...
>
> What is in question is whether the balance between offering monetary compensation and taking other forms of action such as the provision of comprehensive through-life health care and rehabilitation are in the best interests of individuals and of the nation. It should be noted that acceptance of monetary compensation by those assessed as eligible for the Special Rate of Pension significantly constrains their future lives by heavily restricting their opportunities to work.[27]

4.26 Mr Allan Anforth, a barrister, argued that the VEA would not provide inadequate compensation for veterans compared to the SRCA and MRCA in most cases. He noted that the level of incapacity benefits paid under SRCA and MRCA for a veteran unable to work (at 75 per cent of the index normal weekly earnings at

24 *Submission 378*, p. 1.

25 *Committee Hansard*, 5 May 2017, p. 23.

26 *Committee Hansard*, 5 May 2017, p. 22.

27 *Submission 216*, p. 12.

the time of injury) is 'vastly greater than the level of disability pension paid under VEA including the pension paid at the TPI rate under the VEA'.[28] While the VEA granted access to the Gold Card where the veteran is on the TPI rate under VEA (and a few other special circumstances), Mr Anforth argued that the value of the Gold Card to a veteran or their partner has to be discounted by the sheer loss of incapacity payments, permanent impairment and death benefits payable and the offset from Medicare.[29]

4.27 Several advocates and ESOs argued that lump sum compensation payments were inappropriate for many veterans, particularly younger veterans. For example, the TPI Federation noted that a contentious issue with the eligibility for Special Rate Disability Pension (SRDP) was that a veteran must make a life-long choice of whether to take the incapacity payments along with a lump sum or to take the SRDP. It stated:

> There is no provision to change back to the other alternative if an incorrect decision has been made. MRCA provides funding for the member to gain advice from a Financial Adviser prior to making a decision on this course of action. The TPI Federation contends that most Financial Advisers would, in most cases, recommend the Lump Sum Payment, which comes with the Incapacity Payment until age 65, as this is a bias to receive a commission.
>
> Where a young person is faced with the proposition of obtaining a very large sum of money or a small fortnightly compensation payment, the overriding temptation to take the lump sum payment is extreme. They do not think of the ramifications of when they 'hit the wall' and are no longer able to work and earn a living. In this case they cannot double dip and revert to the SRDP. DVA considers that their job has been done.[30]

4.28 In relation to this issue, DVA noted that it provided compensation up to a statutory limit (currently $2,549.31) to be paid for the cost of financial or legal advice in three separate circumstances. In particular:

> Where a person is chronically incapacitated and meets certain eligibility criteria, a person may be offered the choice to receive the Special Rate Disability Pension (SRDP) in lieu of ongoing incapacity payments. These persons are also offered compensation for the cost of obtaining financial or legal advice in respect of that choice. If the person wishes to choose SRDP, obtaining financial advice is mandatory.[31]

Complexity and inconsistency

4.29 DVA acknowledged that the 'current legislative framework for veteran entitlements is complex, with individuals potentially having compensation coverage under one, two or three Acts, depending on their date of service and date

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28 *Submission 208*, p. 5.

29 *Submission 208*, p. 7.

30 *Submission 307*, p. 1.

31 DVA, response to written question on notice 6 February 2017 public hearing.

of injury'. It observed that this situation 'reflects the evolution of the repatriation system and Government decisions over decades in response to changes in circumstances and expectations'.[32]

4.30 The complexity of the three legislatives schemes and the inconsistency of their application to veterans were a key issues raised during the inquiry. It was identified as a key cause or contributing factor to a range of problems for veterans seeking to access compensation, rehabilitation, health services and other support. For example, the South Australian Government commented:

> This legislative framework is cumbersome, complex, confusing and difficult to navigate for advocates, DVA staff and members of the serving and ex-serving community. In some circumstances a veteran may have a claim under more than one Act requiring the claimant (or their advocate) to make a number of applications to more than one compensatory scheme. The assessment process within DVA requires delegates to have a thorough understanding of all legislation in order to assess the validity of a claim. The complexity of the legislative framework can lead to significant delays to the processing of claims adding unwarranted stress to those involved.
>
> It is worth noting that both the US and Canada operate a single scheme and the UK operates one past and one current scheme. This approach removes any overlap between legislative elements simplifying the process. Consideration should be given to a complete review of Commonwealth veteran related legislation that preserves veterans' entitlements while simplifying the process under a single Act.[33]

4.31 Similarly, Mr John Burrows, an advocate, commented:

> The current veteran legislation is very confusing, complex, not client friendly and from my perspective adds a considerable barrier to providing viable advice, practical guidance and support to veterans, their families and supporting agencies. Having to consult three separate Acts on many occasions to identify eligibility, entitlement and access to benefits can be overwhelming, confusing and simply negates many endeavours to apply for an obtain benefits and support!
>
> The inability to interpret many aspects of the complexities and various combinations available in duel and tri-eligible situations often result in veterans and their families being disadvantaged.[34]

4.32 Colonel David Jamison (rtd) from the Alliance of Defence Service Organisations (ADSO) told the committee:

> [W]e believe a significant factor contributing to the problem lies in the legislative framework on which support to veterans is based. The three rehabilitation and compensation schemes result in a very complicated system that sets up an adversarial claims process and a bureaucratic

32 *Submission 156*, pp 29-30.

33 *Submission 187*, p. 4.

34 *Submission 189*, Supplementary submission 1, p. 9.

> structure that many see as complicated and unfriendly towards veterans seeking support. It is abundantly clear from social media groups that veterans from the more recent conflicts feel alienated and see the system as biased against them.[35]

4.33 Mr Peter Reece argued that it all 'comes back to the legislation' and without 'dramatically simplified' law, policy and administration there 'there will be no improvement'.[36] In this context, he cautioned:

> These changes need to be made before the current DVA I/T systems are reengineered, as set out in the latest Budget. I fear that spending that money on the DVA claims system, based on the current policy and administrative framework will not just be excessively complex and expensive, but will lock in a policy which is simply decrepit.[37]

4.34 Other issues were also highlighted. For example, Mr Peter Thornton considered that 'some of the issues surrounding claims processing stems from legislation [and] regulation being too prescriptive [which] in turn limits and restricts the flexibility and discretion departmental Claims and Reviewing Officers have, when dealing with and satisfying claims'. He recommended that DVA Claims and Reviewing Officers be provided with increased levels of discretion in determining claims.[38]

4.35 The impacts of the differences and inconsistencies between each legislative scheme were also emphasised by submitters. For example, ADSO submitted that the differences between the VEA and the MRCA 'colour the veteran community's perceptions of MRCA'. It stated:

> Advocates with long VEA experience perceive MRCA to be complex. As a result, some advocates are known to refuse to support veterans that are subject to MRCA. Through misunderstanding or otherwise, the resulting grievances are aired angrily on social media.
>
> For those advocates with long experience - and therefore familiarity – with VEA, the recency of MRCA's enactment and, as yet, limited number of judgements cause uncertainty for advocates. The [MRCA's] 'stable and permanent provisions' (ss68, 71 and 199 in conjunction with ss68 and 71) and medical examination provisions (s328, in conjunction with ss325 and 326) are known to frustrate veterans awaiting PI, SRDP and INCAP compensation determinations.[39]

4.36 The VVFA identified a number of 'anomalies or inconsistencies' in the application of the VEA, SCRA and MRCA 'in determining necessary compensation for veterans who have suffered some form of injury or damage while a member of

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35 *Committee Hansard*, 18 November 2016, p. 19.

36 *Committee Hansard*, 5 May 2017, p. 24; *Submission 378*, Supplementary submission, p. 1.

37 *Submission 378*, Supplementary submission, p. 1.

38 *Submission 335*, p. 16.

39 *Submission 172*, p. 14.

the ADF'. For example, the VVFA noted differences in the measurement of incapacity:

> Under the VEA, injuries and diseases do not have to meet a minimum degree of incapacity indicated by percentages or impairment points. However, SRCA uses a 'whole of body' impairment system and a minimum of 10% of 'whole of body' impairment for an injury or disease must be reached before compensation is awarded. Similarly, MRCA contains an 'impairment points system' requiring a minimum of 10 impairment points before compensation is triggered.[40]

4.37 The VVFA stated that the 'imposition of a higher standard of evidence for one group of veterans visà-vis another, and between one Act and another, is not only inconsistent, it is also confusing to veterans'. It recommended a '[c]omprehensive review and comparison of all three Acts and identification of same or similar provisions affecting veterans, including contemporary veterans'. It considered this 'review is long overdue'.[41]

4.38 Ms Lee Withers, a former ADF Transition Manager drew the committee's attention to the unfairness of the inconsistencies between the schemes:

> [I]t was horrendous to try and explain to different soldiers and their partners or parents why, when both sustained the same life changing injuries, one would receive enough money to support themselves and medical and physical assistance paid for by DVA, while the other one would not get any ongoing payments or support and a much reduced level of medical care. All they see is they both served together and got hurt together and need the same care and support. They don't care what government decisions changed the levels of care for one because he/she joined on a different date or whatever. That kind of perceived injustice is going to stick for years and years and coupled with other issues post discharge such as lesser income, injury/pain management and mental anguish, is enough to tip someone over the edge.[42]

4.39 An advocate, Mr Rod Thompson, considered the three legislative schemes are 'for the most part are not mutually compatible for veterans' who have multiple deployments and eligibility'. He highlighted that there were many 'different types of service (warlike, non-warlike, hazardous, operational, peacekeeping and peacetime) over approximately 84 gazetted and scheduled conflicts / operations'.[43] He argued:

> An injured / ill veteran is the same whether they are 18 or 80, currently we are seeing SRCA and a significant number of MRCA veterans becoming a sub-class of veteran not being provided with the Beneficial provisions and

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40 *Submission 277*, p. 10.

41 *Submission 227*, pp 11-12.

42 *Submission 22*, p. 1.

43 *Submission 334*, p. 12.

> concessions (both state and federal) provided to those solely under the VEA.[44]

4.40 The TPI Federation highlighted that currently some TPI veterans are denied access to a number of DVA services 'purely because they don't have operational service'. It stated:

> This is discriminatory and a failure to recognise that a non-operational TPI suffers the same consequences as an operational TPI even to the extent of not having access to a service pension at age 60, but must rely on a Centrelink Disability Support Pension. A salient point, worth remembering, is more service people have been killed or injured in non-operational theatres since the Vietnam War; by example the Black Hawk tragedy, the WESTRALIA incident and other numerous non-operational occurrences that have caused fatalities or injury.[45]

4.41 To illustrate the range of differences between the schemes, TPI Federation noted that 'under the MRCA, a DVA client's family is currently eligible to $11,654 as a funeral allowance [but this] is markedly different with the VEA client's family where the same allowance is $2,000'.[46]

4.42 Similarly, Mr Frank O'Neill questioned the rules which could impact veterans when their partner was employed:

> The means tested Service Pension of a maximum amount of $22,804 pa for single disabled is added to the TPI rate which at the combined maximum amounts to $57,804 pa. However the Service Pension is withdrawn when the single veteran marries someone participating in the workforce…I walked down the aisle single as a $58,000 pa man. I walked back up the aisle married a $35,000 pa man. There was no miracle health cure at the alter to explain why the DVA System cut my replacement income by 40 percent.[47]

4.43 Others argued that a realistic approach to reform of veterans' compensation would be necessary. Mr Peter Larter advised the committee:

> The complexities in the framework and legislation, in the [VEA] and all the acts are better for some and worse for others. If you were to draw a line in the sand—and I think there could be a future for this—the most important person in the room would be the Treasury department that needs to sign off. I do not think it would be fair to a veteran who, in certain situations, in one act—and even in the MRCA Act, which is a new one—will be worse off in his entitlements than someone under the VEA or SRCA. A roomful of good advocates would be able to give you plenty of examples of that.

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44 *Submission 334*, p. 14.

45 *Submission 307*, p. 3.

46 *Submission 307*, p. 5.

47 *Submission 305*, p. 12.

> But that comes at a cost: a cost to government, a cost to the taxpayer et cetera; I understand that. So, if we were to go forward, I do not think it would be fair for the veteran to go backwards in entitlements. More than likely we would be going forward with entitlements, and that will come with a dollar value…[48]

Non-liability health care

4.44 There was significant positive feedback during the inquiry concerning the expansion of non-liability health care for all mental health conditions. Some recommended that further expansion of non-liability heath care should be explored to reduce complexity and simplify administrative processes.

4.45 For example, Dr Jon Lane, a consultant psychiatrist, noted that since the expansion of non-liability healthcare coverage for mental health and substance abuse problems he had seen an increase in veterans. He described this as 'a very good thing', noting it 'demonstrates that opening access to services with minimal administrative requirements works in terms of Veterans accessing these services'. He recommended that the Government extend the non-liability health care to all service veterans, for all health conditions. He stated:

> This may have an initial higher cost, but as seen with the limited access to specific mental health conditions now, it would improve access to treatment, and therefore reduce the overall level of treatment required, as well as the duration of that treatment. This should reduce the administrative cost and workflow burden to DVA in terms of the liability determinations which are the majority of the basis for complaints, as well as the ongoing administrative and treatment costs by ensuring that veterans get adequate and early treatment for problems.[49]

4.46 This proposal was also raised in the Joint Standing Committee on Foreign Affairs, Defence and Trade's (Joint Committee) report on the *Care of ADF Personnel Wounded and Injured on Operations* in 2013. The Joint Committee was 'concerned that a significant difference exists in the treatment of personnel who discharge with a condition that is recognised by DVA, and those who discharge and subsequently develop a service-related condition'. It recommended that the Government conduct a cost-benefit study of a comprehensive uncontested veteran healthcare liability model and publish the results.[50] However, this recommendation was not supported. The Government response stated:

> Any proposal to further extend "non-liability" access to DVA health care arrangements to a broader group of former service personnel would involve significant additional financial costs to the Commonwealth and is not a priority at this time. Also under DVA arrangements comprehensive health

48 *Committee Hansard*, 5 May 2017, p. 13.

49 *Submission 78*, pp 1-4.

50 Joint Committee report, pp 96-97.

> care is available for treatment of conditions which have been accepted by the Department as service related.[51]

4.47 DVA noted that any further expansion of on-liability health care would need to be considered by Government in the Budget context:

> Financial modelling can be based on existing non-liability health care recipients and generally applied to extensions. Some costs will be partially offset with the Department of Health. Data on incidence rates and estimates of those with one or more additional mental health conditions co-occurring with an existing non liability health care mental health condition are also relevant when providing advice to Government on the costs associated with extending non-liability health care options for veterans.[52]

Support for a review

4.48 In the context of the issues raised above, many submitters expressed support for a large scale review of military compensation and the framework of entitlements for veterans often proposing a focus on simplification. For example, Mr Peter Reece, a former DVA official, critically assessed each of the previous reviews of military compensation arrangements considering they had 'only deal superficially with operational issues with the current legislation'.[53] He considered that there was a need for a comprehensive basic 'ground-up review of military compensation'. Due to it being an 'enormous, longstanding, complex and very detailed issue' he considered it would be a task for 'the Productivity Commission or a judicial inquiry of some kind, something with a lot of horsepower'.[54] He stated:

> The outcomes, I would hope, would be the rationalisation of the scheme into something which every other public servant and citizen in this country enjoys—that is, good, sensible, transparent and fair compensation…The outcomes ought to be rationalisation and, I dare say, some savings in costs, because remember that Veterans' Affairs these days has a budget of $12½ billion, which is the annual downstream cost of Defence. It is not counted in the Defence budget. But is more than money: I do not really mind how much veterans are paid, so long as it is fair, even, consistent, simple and easily administered; it is none of those things.[55]

4.49 The RSL noted that the last major review was in 2011 and considered that 'it would be prudent to have another look at the interplay between the various Acts and the effectiveness of the administration of those Acts by the DVA'. It recommended:

> That an independent Review be set up, with broad Terms of Reference, to investigate the interplay between the three extant Acts administered by

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51 Government response to Joint Committee report, December 2013, pp 6-7.

52 DVA, responses to written question on notice, public hearing 6 February 2017, p. 1.

53 *Committee Hansard*, 5 May 2017, p. 19.

54 *Committee Hansard*, 5 May 2017, p. 19.

55 *Committee Hansard*, 5 May 2017, p. 20.

> DVA, their procedural interaction with ComSuper, and whether having three separate Acts remains an effective approach to the support and compensation of veterans in Australia.[56]

4.50 Mr Arthur Ventham, Chair of the Northern Suburbs Veterans Support Centre, also highlighted it was five years since the last review. He stated that 'in the current environment, it would be prudent to have another look at the interplay between the various Acts and the effectiveness of the administration of those Acts by the DVA which on the surface appears to have become extremely dysfunctional'.[57] Like many submitters, the Northern Suburbs Veterans Support Centre argued that the objective of legislative reform should be a single piece of legislation to cover compensation and rehabilitation for all veterans. It proposed:

> A new Rehabilitation and Compensation Act be developed to replace VEA, SRCA and MRCA so that unjust discrimination that is found today is eradicated and all Members are treated equally when it comes to rehabilitation and compensation.[58]

4.51 Similarly, Mr Ben Johnson, a former senior public servant, proposed that legal advice be sought from 'the Office of Parliamentary Council (OPC) in the Attorney General's Department on options for either preparing an Omnibus Amendment Bill to consolidate the current complexity of DVA managing both the VEA and MRCA' and 'streamlining of the claim processes for veterans and the assessment of compensation and support for injuries incurred as a result of different periods of service'. Alternatively, an MRCA amendment which would 'effectively triage or prioritise the claims from contemporary veterans to ensure that those veterans with the most serious medical claims are assessed with the highest level of priority accorded a rapid resolution of their claim'.[59]

4.52 Some argued for the establishment of a Royal Commission.[60] For example, the Royal Commission into DVA Working Group had 'no faith in the current senior and middle management of DVA's capability to rectify over a decade of neglect, we consider the only option to be a Royal Commission that can make binding legal directions to DVA looking into all aspects of the Repatriation System, Defence Transitions and the Wider Veteran Landscape including ESOs'. It stated:

> [A]ll the reports and findings of recent inquires have contained the two words, COMPLEXITY and SIMPLIFICATION. Neither of which have been addressed by DVA's senior management, in fact DVA has embarked on further complication with the introduction of the proposed DRCA legislation making five conflicting legislations creating sub-classes of veterans many falling below the poverty line struggling with homelessness

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56 *Submission 216*, p. 9.

57 *Submission 295*, p. 5.

58 *Submission 279*, p. 5.

59 *Submission 264*, p. 7.

60 For example, Mr John Lawler, *Submission 7*, p. 22.

> and financial stress all while suffering in some cases significant mental and physical injuries exacerbated by an adversarial and complex system and all the bureaucracy that comes with 5 separate and conflicting legislations.[61]

4.53 However, DVA observed that the idea that there should be a single piece of veterans' affairs legislation has been examined in a number of inquiries, most recently by the MRCA review in 2011:

> The [MRCA review] Steering Committee noted that the MRCA was introduced to address the complexities created by the concurrent operation of the [VEA] and the [SRCA]. However, as it is still possible for claims to be made under the VEA or SRCA for conditions arising from service before 1 July 2004, the operation of these three Acts continues to create complexity and confusion for some claimants, particularly for those who have coverage under more than one of these Acts. It is likely that this situation will remain for some time to come, because while MRCA claims will become the majority of claims received in the decades to come, claims under the VEA and SRCA will not be exhausted for many years.
>
> After considering options for simplifying DVA's legislative framework, the [MRCA review] Steering Committee concluded that consolidating entitlements into one Act would be extremely difficult and would require the resolution of several complex, sensitive and potentially controversial issues, including the fact that compensation entitlements under the three Acts are structured differently.[62]

4.54 DVA outlined a number of reasons why 'there is no simple, singular approach to address or fix the current legislative complexities'. These included:

- there are accrued rights issues in changing entitlements once they have been accrued through periods of service;
- complex transitional arrangements would be needed to protect existing entitlements and ensure no detriment to individuals; and
- uniform compensation benefits could be seen as inconsistent with the nature of military service, and would imply, or could be interpreted to mean, that all military service is the same.[63]

4.55 DVA noted that it was 'identifying opportunities to align and streamline its practices and procedures within the current legislative framework to make it simpler for DVA clients to understand what they are entitled to and how to claim'. It also highlighted that the amendments creating the DRCA 'give the Minister for Veterans' Affairs policy responsibility for all relevant compensation legislation for ADF members and veterans'. It pointed out that the DRCA would 'enable the Minister and the Military Rehabilitation and Compensation Commission to

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61 *Submission 453*, pp 22-23.

62 DVA, response to written question on notice from public hearing 6 February 2017.

63 DVA, response to written question on notice from public hearing 6 February 2017.

consider possible changes to align the Act with the MRCA, which would not have been appropriate for civilians with coverage under the Act'.[64]

The Repatriation Medical Authority (RMA) and Statements of Principles

4.56 The Repatriation Medical Authority (RMA) is an independent statutory authority, based in Brisbane, responsible to the Minister. The RMA consists of a panel of five practitioners eminent in fields of medical science. The role of the RMA is to determine Statements of Principles (SOPs) for any disease, injury or death that could be related to military service, based on sound medical-scientific evidence. The SOPs state the factors which 'must' or 'must as a minimum' exist to cause a particular kind of disease, injury or death. The SOPs are disallowable instruments which are tabled in Parliament and are binding on various decision makers.[65] The RMA explained:

> In determining SOPs, the RMA is required to rely upon sound medical-scientific evidence (SMSE), as defined in section 5AB of the VEA…All available SMSE is evaluated by the RMA against accepted epidemiological criteria. These criteria include strength of association; consistency; specificity; temporality; biological gradient; plausibility; experimental evidence; and analogy and may not each be relevant in all decisions of whether or not a factor should be included in a SOP.[66]
>
> The VEA and MRCA provide for two different standards of proof which apply to claims for compensation by veterans and serving members. The RMA is also required by the legislation to apply two standards of proof when determining the contents of SOPs. For each condition, two SOPs are determined.
>
> The more beneficial standard, known as the "reasonable hypothesis" standard, applies to veterans and serving members who have operational (or equivalent) service….The less beneficial "balance of probabilities" standard (also known as reasonable satisfaction) applies to eligible war service (other than operational service) and defence service (under the VEA), and peacetime service (under the MRCA).[67]
>
> The different standards of proof will often lead to some factors being included in the "reasonable hypothesis" SOP with weaker evidence than is required for inclusion in the "balance of probabilities" SOP. The "reasonable hypothesis" SOP will often contain more causal factors and/or the specified exposure contained in a factor may be easier to satisfy. The result is that it is generally easier for veterans and members with

64 DVA, response to written question on notice from public hearing 6 February 2017.

65 See 'Introduction to the RMA', available at http://www.rma.gov.au (accessed 12 September 2016)

66 RMA, *Submission 32*, pp 2-3.

67 RMA, *Submission 32*, p. 4.

> operational service to successfully claim that a medical condition was related to their service.[68]

4.57 In 1997, a review was conducted of the RMA and the Specialist Medical Review Council (SMRC) the body which was created to hear appeals against decisions of the RMA relating to the making of SOPs. The reviewer, Professor Dennis Pearce, while making recommendations for improvement, concluded that the amendments creating the RMA and SMRC had created 'a more equitable system for the compensation of veterans' which was 'more efficient and non-adversarial than that previously existing'.[69]

4.58 The Joint Committee report on *Care of ADF Personnel Wounded and Injured on Operations* included a recommendation that DVA 'review the Statements of Principles in conjunction with the Repatriation Medical Authority with a view to being less prescriptive and allowing greater flexibility to allow entitlements and compensation related to service to be accepted'. However, the government response to the Joint Committee report did not support this recommendation. It stated:

> While the Department of Veterans' Affairs (DVA) seeks to be flexible in its service delivery to clients, introducing flexibility to the Statements of Principles regime would undermine its purpose and reduce its value in underpinning evidence based decisions…The Statements of Principles regime is a well established and core element of the Repatriation system. They are internationally recognised as providing a quality decision making tool. There is strong support for the Repatriation Medical Authority and the Statements of Principles regime from ex-Service organisations and the ex-Service community.[70]

4.59 The RMA has a schedule for regular review of its SOPs and reviews the contents of each SOP at least once every 10 years (7 to 8 years on average). The RMA monitors developments in medical science and epidemiological understanding of disease aetiology. Where it becomes aware of significant new sound medical-scientific evidence, it initiates reviews of the relevant SOPs earlier than the usual cycle. SOPs are also reviewed more frequently where a request is received from an eligible party to do so with sufficient relevant information to support the request.[71]

4.60 The RMA indicated that for the period January 2014 to December 2016, the RMA received 63 requests to undertake investigations or reviews.[72]

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68 RMA, *Submission 32*, p. 5.

69 Professor Dennis Pearce, *Review of the Repatriation Medical Authority and Specialist Medical Review Council*, 1997, p. iii.

70 Australian Government, *Government response to JSCFADT report into Care of ADF Personnel Wounded and Injured on Operations*, December 2013, pp 12-13.

71 DVA, response to question on notice 8, Budget Estimates, 30 May 2017, p. 1.

72 RMA, response to question on notice from public hearing 6 February 2017.

4.61 In particular, during the inquiry, the RMA reconsidered the SOPs concerning suicide and attempted suicide. Mr Peter Larter's submission included his request to the RMA to review this SOP, in particular factors 3 and 4 which 'stipulate that a person must experience a 1A or 1B stressor within 2 and 5 years before the suicide in order to establish that death from suicide is connected to a person's relevant service'. Mr Larter noted:

> A situation presents itself where a spouse or dependent may not be able to connect the person's suicide to relevant service where the suicide occurred after 2 and 5 years from date of experiencing the category 1A or 1B stressor and they cannot establish enough evidence to satisfy any other factor in the SOP.
>
> It is possible that a person with relevant service has a delayed onset (more than 5 years) of a significant disorder of mental health and has not received or being treated for any impairment regarding symptomology of a mental health condition.
>
> In this instance the surviving spouse or dependent claim for compensation will fail and they will be ineligible for any entitlements as the suicide occurred after the 2 and 5 year time period as stipulated in the SOP's.[73]

4.62 Consequently, the RMA made beneficial changes regarding these SoPs:

> The RMA's assessment of the sound medical-scientific evidence relating to suicide was that it supported a causal link between both exposure to a category 1A stressor, and a clinically significant mental health disorder, and suicide where the suicide took place within five years of exposure to the stressor. Where a suicide occurred more than five years after experiencing the stressor, the RMA considered that the suicide was likely to be related to the stressor via another causal pathway, most probably one of the specified mental health conditions.
>
> In response to a request for review of the time frames, the RMA has recently reviewed the available sound medical-scientific evidence. The RMA has now concluded that the limited evidence in support of the timeframes, together with the difficulties being experienced by claimants in posthumously establishing the existence of a clinically significant disorder of mental health, warranted removing the current time frames applying to category 1A and 1B stressors. The Amendment Statements of Suicide (Instruments Nos. 26 and 27 of 2017) have now been lodged with the Federal Register of Legislation and will take legal effect from 27 March 2017.[74]

4.63 There was dissatisfaction expressed amongst submitters with how the SOPs were being developed and applied. Professor Nick Saunders, Chair of the RMA, acknowledged:

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73 *Submission 1*, p. 1.

74 RMA, response to question on notice from public hearing 6 February 2017.

> The most common issues that have been raised seem to us to be that the statements of principles are not up to date, that they are inflexible, that they are too complex for non-expert people to use with ease, that they are designed to hinder rather than assist veterans who are seeking to make a claim and that the use of two standards of proof to write the statements of principles is inherently unfair.[75]

4.64 However, Professor Saunders noted that SOPs were introduced to create a transparent and consistent system which now covers 93 per cent of claims made. He commented:

> Each statement of principle is based on sound medical scientific evidence that is available to the authority at the time that the SOP is written, and that evidence is identified by an extensive search of the English-language medical and scientific literature. The SOPs provide an exhaustive list of factors that are known to cause the disease, illness or injury under consideration. The list of factors is based on a generous interpretation of the evidence, and a veteran only needs to establish one factor for the claim to be successful.[76]

4.65 Criticisms of the SOPs focused on their rigid application to the situation of veterans. The ADSO commented that while the SOPs provide a high level of certainty for an ESO's Compensation Advocate when assessing the probable viability of a claim or appeal, the 'inflexible application of the SOP Risk Factors in determining veterans claims was inconsistent with the beneficial intent and provisions of the legislation'.[77]

4.66 Similarly, Mr Brian Briggs from Slater and Gordon Lawyers noted:

> When compared to a common law claim, or a claim being assessed under the SRCA, the Statements can be seen as quite limiting in terms of the assessment of liability. This is because a claim will be rejected if at least one of the factors in the applicable Statement is not proven, even if the claimant has medical evidence or opinion from a qualified specialist, linking the onset of their condition to some event, injury or activity occurring during service.
>
> Further, the strict time frames within the Statements, which relate to the date of onset of symptoms relative to the date of initial trauma or injury cause particular difficulty. Often, our clients discover when going through the claims process that an injury or trauma they have suffered has not been properly documented by Defence medical staff…[78]

4.67 He recommended that to alleviate these issues an acknowledgment or direction be inserted within the legislation or SOPs to the effect that the SOPs are to be used as a guide only. Further, he suggested amendment of the SOPs 'to extend

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75 *Committee Hansard*, 6 February 2017, p. 36.

76 *Committee Hansard*, 6 February 2017, p. 36.

77 *Submission 172*, Supplementary submission 172, p. 1.

78 *Submission 160*, p. 24.

or remove the strict time frames frequently inserted to dictate when "onset" must occur following specific events'.[79]

4.68 A joint submission from Dr Catriona Bruce and others noted that 'the RMA's definition of a condition does not necessarily correspond with a doctor's diagnosis of a condition in terms of normal standards of modern medicine'. They considered this discrepancy means that veterans are unlikely to be able to have their medical conditions comprehensively categorised and recognised under the RMA system. They proposed:

> Restore benefit-of-doubt to veterans. Interpretation of Veteran Legislation was intended to be in the interest of the veteran. This concept has now been set aside, and the onus of proof is now on the veteran. Claims outside a defined RMA Statement of Principles (SoP), but supported by registered specialist Medical/Psychiatric practitioners should be accepted.[80]

4.69 RSL (Tasmania) considered that while 'SOPs do provide a degree of certainty and consistency in claims decisions when properly applied, they do create an anomaly when military compensation claims are compared to civilian claims where the circumstances of an injury are similar'. It noted that the SoPs do not apply to claims under the SRCA, but that DVA has indicated that delegates should be 'guided by' the SOPs.[81]

> One difficulty with SOPs is that they are based upon the totality of available sound medical evidence for causative factors of a condition, while claims not based upon an SOP are based upon medical opinion and the suggestive evidence of a claim. This creates an anomaly in that, under the balance of probabilities, medical opinion and the circumstances of a claim may suggest a link between a condition or injury and a claimant's service. However, the totality of available medical research may suggest that the evidence for causation is not strong enough to create a statistically significant link. This means that the research suggests that a link might be possible, but not probable statistically and therefore not worthy of inclusion in and SOP, while medical opinion available in a particular case, along with the evidence available in a particular case might be sufficient to meet the legal balance of probabilities test required by the Acts.
>
> The difficulty here is that, under VEA and MRCA, SOPs have the force of law, so they are required to be used, even though they may set the bar higher than what is strictly required by the legal test required in the Acts.[82]

4.70 The RSL (Tasmania) observed this situation raises a series of difficult questions relating to 'the interactions of two potentially different standards of proof (statistically significant evidence of causation in medical research versus the legal balance of probabilities test, which is less rigorous), potential disadvantages to

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79 *Submission 160*, p. 24.

80 *Submission 171*, p. 2.

81 *Submission 169*, p. 12.

82 *Submission 169*, p. 12.

military claimants introduced by these differences, and public interest questions with regard to consistency of determinations'.[83]

4.71 Mr Anforth observed that the SOPs were original introduced 'to do away with the cost and repetition of veterans having to prove the medical causation issues case after case'. However, he argued that this has been lost in subsequent statutory amendments. He noted that in non-operational service cases, even if a SOP is satisfied, a claim can still be denied on the basis of other evidence that contradicts the proposition of the SOP. Further, even if there is a large body of expert medical evidence pointing to the service cause of the injury, if the SOP is not satisfied the claim fails. He described as 'unfair' that if the 'SOP does not favour the veteran then the veteran cannot rely on other evidence to support what may otherwise be a valid claim'.[84]

4.72 DVA appeared to confirm this assessment of the rigid application of the SOPs to claims. It stated:

> The Commission must apply SoPs and accordingly, it does not (and cannot) seek evidence which contradicts the relevant SoP in the circumstances of an individual case. Claims are decided on the basis of the totality of evidence available to the Commission, with the relationship of the claimed condition to the veteran's service being determined according to the relevant SoP.
>
> DVA does not have any discretion in applying existing SoPs and must apply the factors strictly as they appear in the SoPs to claims made under the [VEA] and the [MRCA].[85]

4.73 Other views were also expressed. The RSL was supportive of the objective approach to evidence that is at the heart of the SOPs and noted that New Zealand has recently moved to incorporate the idea of SOPs into their veterans support framework.[86]

Conclusion

An independent review

4.74 A key contextual factor in the administrative burdens described by veterans in dealing with DVA is the complex legislative framework. With the notable exception of DVA, there was broad support expressed for a review aimed at simplification of the legislative framework. Many submitters argued for simplification of the current arrangement under the VEA, SRCA and MRCA, others supported reforms to create a single legislative scheme. Specific aspects of unfairness and inconsistency in the current arrangements which could be rectified were identified. The point was repeatedly made that excessive legislative complexity was a burden on veterans, advocates and the operations of DVA itself.

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83 *Submission 169*, p. 13.

84 *Submission 208*, p. 9.

85 DVA, response to written question on notice from public hearing 6 February 2017.

86 *Submission 216*, p. 10.

4.75 The committee considers that a system which is as complex and challenging to navigate as the current arrangements will compromise any efforts to make claim processes 'veteran centric'. It is apparent that the Australian Government, through recent legislative amendments (such as the DRCA), is laying the groundwork for a simpler set of military compensation and rehabilitation arrangements. Unfortunately, the committee does not have the resources to determine the most effective arrangement of the complex range of benefits, entitlements, rehabilitation and compensation schemes in relation to serving members and veterans.

4.76 The terms of reference of the inquiry directed the committee to investigate the 'failings' of previous reviews of military compensation arrangements. However, in the view of the committee the previous reviews have been undertaken diligently and appropriately. Incremental and beneficial reforms have been made to military compensation arrangements based on the findings of these reviews. It is also appropriate to acknowledge that not all recommendations of these previous reviews have been accepted and implemented by the Australian Government.

4.77 However, previous reviews of military compensation arrangements and the incremental reforms which were adopted have contributed to the overall complexity of arrangements. Many of these reviews have been undertaken or primarily supported by DVA and Defence officials. While this has the advantage of incorporating institutional knowledge, it also risks institutional inertia. The committee considers that the previous recent reviews of military compensation arrangements have been too willing to accept the status quo. The committee agrees with the many submitters who argued that a robust independent review of military compensation arrangements was needed to re-examine long-standing issues in this portfolio.

4.78 It is time for a comprehensive rethink of how the current system operates and will operate into the future. As Colonel Rob Manton, Director of Veterans SA, advised the committee, any reforms will needs to be directed 'at the next 50 years' taking into account the many veterans of the deployments which have occurred since Australia's involvement in Timor-Leste in 1999.

4.79 In conducting this review, there should be no topics which are off-limits including the differences in relation to operational service, standards of proof and the provision of services through DVA or alternative government agencies. The committee recognises this will not be an easy or uncontroversial review process. Systemic reform may even moderately disadvantage some individual veterans in the process of improving outcomes for serving members and veterans overall.

4.80 A large scale review will require a public research organisation, or an independent taskforce, with established policy and economic analytical capabilities. In particular, it should be able to draw on the expertise of DVA and Defence officials but should be substantially independent. In the view of the committee, the Productivity Commission would be appropriate to undertake this systemic review and make recommendations to the Australian Government for changes to streamline the legislative framework for the benefit of serving members and

veterans. The terms of reference for this review should be directed to simplification, efficiency and achieving fair outcomes.

Statements of Principle

4.81 The SOPs prescribe the factors which must as a minimum exist before a reasonable hypothesis can be said to be raised connecting an injury or disease with a person's service. While the SOPs prepared by the RMA appear to promote consistency in decision making, examples were raised where they have been applied rigidly and unfairly. In the view of the committee, this structure can be unduly restrictive on claims in specific circumstances which is not in keeping with the beneficial objective of veterans' entitlements.

4.82 During the inquiry the SOPs in relation to suicide and self-harm were reviewed by the RMA and updated. Amendments such as this inevitably lead to questions about earlier claims by veterans which were rejected due to previous more restrictive interpretations of the factors listed in SOPs. It is unfair that a person who has rendered military service and been injured would be unable to claim for that injury because a body of sound medical evidence linking that injury to their service has not been developed at that point. The psychological impact on veterans of having a legitimate claim rejected in these circumstances would be immense.

4.83 The committee considers that there is sufficient justification to re-examine how the SOPs are utilised in the determination of compensation claims. Given the frequently cited 'beneficial' nature of the VEA and the MRCA, it is inappropriate that system of SOPs would be rigidly applied. This situation is particularly acute in relation to veterans without operational service.

4.84 A better system might be one closer to that envisaged by the Baume review with one standard of proof (the civil standard, with a benefit of doubt in favour of veterans with relevant operational service), initially determined by the delegates primarily guided by the SOPs prepared by the RMA. However, delegates should not be completely bound by the SOPs. Keeping in mind, the beneficial nature of entitlements for veterans, delegates should have within their discretion the capacity to determine claims provided there is a reasonable link to a person's service on the balance of probabilities. However, this matter should be considered in detail by the review.

Recommendation 6

4.85 **The committee recommends that the Australian Government make a reference to the Productivity Commission to simplify the legislative framework of compensation and rehabilitation for service members and veterans. In particular, this review should examine the utilisation of Statements of Principle in the determination of compensation claims. The report of this systemic review should be completed within 18 months and tabled in the Parliament.**

Chapter 5
Administration issues

Introduction

5.1 Commentary on the administration of veterans' entitlements by DVA was present in the bulk of submissions received for the inquiry. This chapter will consider DVA's role in administration and examine the progress of recent reform. It will outline some of the common issues raised during the inquiry including staffing issues and delays. Finally, it will examine the use of the Compensation for Detriment Caused by Defective Administration (CDDA) scheme in relation to DVA.

Department of Veterans' Affairs

5.2 DVA is the primary agency responsible for policy development and implementation of programs intended to assist veterans and their families. DVA also provides advice, administrative support and staff to the Repatriation Commission and the Military Rehabilitation and Compensation Commission (MRCC) which have responsibilities under the VEA and MRCA respectively. DVA will administer $10.9 billion of funding in the 2017-18 financial year. The total departmental annual appropriation for 2016-17 was $375 million (estimated actual).[1]

5.3 In June 2016, Department of Veteran's Affairs (DVA) estimated there were 329,200 living veterans, down from the estimate of 382,800 in June 2012.[2] As at 31 March 2017, there were 293,874 DVA clients.[3] Projections of beneficiaries in receipt of pensions, allowances or health care indicate a declining number of veterans and dependents. Total veterans receiving these benefits are forecast to fall from 165,760 in December 2016 (actual) to 154,000 in June 2020 and 129,100 in June 2030. Total dependents are forecast to fall from 131,296 in December 2016 (actual) to 101,600 in June 2020 and 58,300 in June 2030.[4]

5.4 DVA's annual report for 2015-16 noted while overall VEA beneficiary numbers have declined over the past four years, the numbers of SRCA and MRCA beneficiaries have been rising:

> Over the past four years there has been a 98 per cent increase in the number of MRCA veterans with an accepted disability. The number of MRCA veterans who have received a permanent impairment payment has increased from 2,246 to 7,659 (241 per cent). Despite the significant growth in numbers of MRCA clients, the numbers of new clients from the VEA,

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1 DVA, *Portfolio Budget Statement 2017-18*, Budget Related Paper No. 1.4B, pp 69-70.

2 DVA, *DVA Projected Beneficiary Numbers with Actuals to 31 December 2016*, p. 1.

3 DVA, response to question on notice 43, Budget estimates, 30 May 2017, p. 1

4 DVA, *DVA Projected Beneficiary Numbers with Actuals to 31 December 2016*, p. 1.

MRCA or SRCA will not significantly impact upon the overall downward trend in client numbers. [5]

5.5 The growing number of MRCA clients has implications for DVA's administrative burden. While VEA clients usually have a relatively stable relationship with DVA, MRCA and SRCA clients can have a more episodic relationships, in that they may apply and be assessed for a lump sum payment, be reimbursed for medical costs, and come in and out of income replacement.[6]

Table. DVA clients, expenditure and health cards

Scheme	DVA clients	Compensation and support expenditure (2015-16)	Health expenditure (2015-16)	Gold cards	White cards
VEA	225,933	$5.74 billion	$4.64 billion	135,766	39,900
MRCA	25,224	$309.9 million	$64.7 million	1,373	12,820
SRCA	51,926	$130.7 million	$38.2 million	n/a	5,362[7]

5.6 Broader issues regarding the appropriate responsibilities of DVA in delivering services to veterans were raised by some submitters. For example, Mr Arthur Ventham, Chair of the NSVSC, observed that some 'service delivery agencies have been absorbed into the Department of Human Services (DHS)'. He observed that '[e]ven in the past few months we have seen the closure of one or more DVA Country Offices and its operations now being handled by Centrelink'. Mr Ventham urged the committee to recommend DVA remain as a stand-alone department and to allocate sufficient funding to ensure that it continues to provide support to the veteran community.[8]

5.7 Similarly, the RSL described future reform of DVA as 'not well illuminated'. It was 'concerned that the long term future of the DVA may be solely as a policy-development rump, while the bulk of its service delivery functions, and indeed expertise in the management of veterans support is absorbed into the DHS'.[9]

5.8 The TPI Federation highlighted that veterans and their families were only a small portion of the Australian population. Other departments and agencies 'know little, if anything, of the Veteran's issues or entitlements and much needed consideration of their conditions'.[10] Accordingly, it considered that it was 'imperative that all DVA clients continue to have DVA as their ally'. Instead of requiring veterans

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5 DVA, *Annual report 2015-16*, p. 12.

6 DVA, *Annual report 2015-16*, pp 15-16.

7 DVA, *Stats at a Glance*, March 2017.

8 *Submission 295*, p. 9.

9 *Submission 216*, p. 9.

10 *Submission 307*, p. 2.

to deal with other departments, 'DVA should have the facility to contact these other departments, get the requirements for any issue, then go back to the DVA client with a result'.[11]

5.9 Others had contrasting views. Mr Ben Johnson, a former senior public servant, noted that DHS currently has responsibility for efficiently managing government payment to families, welfare recipients and others. He pointed out it could be argued that 'DHS can provide much more efficient payment mechanisms for veterans/ex-service personnel rather than them having to deal with the inefficiency of DVA attempting to manage payments to veterans'. Such a consolidation of payment functions across government would be consistent with the previous Australian Public Service (APS) Whole Of Government (WoG) Blue Print for Reform. Mr Johnson stated that 'WoG payment reforms would enable resources to be better directed to support efficient payments to veterans, ex-service personnel and their families rather than continuing to fund DVA for administering inefficient costly payments on dated data systems'.[12] He recommended:

> DVA be required to work with DHS to deploy a 'Tell Us Once' client integrated service model in 2017 for all veterans and ex-service personnel to ensure that personal data and claims details do not have to be re-submitted to DVA on multiple occasions or lodged for different purposes under different Acts.[13]

5.10 Some such as Mr Peter Reece, a former senior DVA official, argued for Defence to take greater long-term responsibility for injured veterans. He stated 'they break them, they should fix them':

> Defence as the employer needs to retain full responsibility for the entire treatment/rehabilitation and retraining/redeployment process. They should no longer be able to so readily pass the parcel to DVA. DVA should have no responsibility for ex Defence personnel, except perhaps for compensation assessment and payment down the track as an epilogue, not a prologue. However, I go further and suggest there should be no need for DVA at all if a modern civilian type compensation system was installed – but the screams can already be heard for any suggestion that defence should have all ADF personnel managed by COMCARE...but why not?[14]

5.11 RSL DefenceCare also argued it was time to consider 'radical change to remove the stress associated with DVA claims'. It suggested:

> Many government services are outsourced and there is no reason why assessment and approval of claims could not be undertaken by non-government professional organisations. If we continue to follow the same practices, we will continue to see the same results….With the rise of

11 *Submission 307*, p. 7.

12 *Submission 264*, p. 4; *Committee Hansard*, 18 November 2016, p. 33.

13 *Submission 264*, p. 5.

14 *Submission 378*, p. 7.

> professional organisations like RSL DefenceCare, there should be a number of organisations capable of tendering for the provision of this type of service.[15]

Progress of reforms

5.12 In 2013 the Australian Public Service Commission (APSC) conducted a Capability Review of DVA. It found that 'the environment in which DVA operates has changed at a much faster pace than the speed with which the department has allowed itself to change':

> The older client base continues to decline while the new younger client base has different expectations. The fiscal pressure facing government today coincides with public expectations of efficiently run government agencies. The concept of shared services—where scale economies are achieved with consistent and increased service levels— is widely spread in the public and private sectors.[16]

5.13 The ASPC review team concluded that DVA faced 'significant challenges to enhance its capability and mobilise its workforce so it can transform into an efficient and effective modern public sector organisation meeting government and community expectations'. It identified three key areas of 'needing urgent attention' for DVA to transform:

- operating structure, governance arrangements and information and communications technology (ICT);
- approach to clients, culture and staffing; and
- efforts to formulate effective strategy, establish priorities and use feedback.[17]

5.14 DVA acknowledged that the 'support required by Australia's veterans is changing: pre-1999 veterans and their dependants continue to age; younger veterans who have served in operations from Timor to the present have different needs, with a greater requirement for tailored and ongoing support services; and finally, in this digital age, veterans expect service delivery to be as seamless as possible, intuitive and coordinated'.[18]

5.15 In response to these challenges DVA stated that it was in the process of transforming its operations 'to put veterans at the centre of everything it does'. As part of this process the 2016-17 Budget for DVA included $24.8 million over two years to develop a second pass business case for Veteran Centric Reform which focused on simplifying and streamlining business processes and replacing legacy information and communication technology (ICT) systems.

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15 *Submission 216*, p. 16.

16 APSC, *Capability Review: Department of Veterans' Affairs*, December 2014, p. 5.

17 APSC, *Capability Review: Department of Veterans' Affairs*, December 2014, p. 5.

18 *Submission 156*, p. 16.

5.16 This was following by a 'significant investment' in the 2017-18 Budget for the first stage of Veteran Centric Reform to allow DVA to 'provide easier access to services and to streamline and help early decision making for claims'.[19] The aim of this reform was to give the veteran community 'a greater standard of service through reform of business processes and culture, identification and implementation of government-endorsed best practice service options and targeted ICT redevelopment'. Veteran Centric Reform would be supported by funding 'to implement a suite of proactive interventions to deliver targeted assistance'. These interventions included:

- analysing the services veterans access through the Department, from car bookings through to health and rehabilitation services, to gain more meaningful insights into the needs of our clients
- identifying common themes across client groups and proactively changing support arrangements to meet their needs
- applying behavioural economics approaches across our business to ensure the programs we provide are best practice
- conducting a trial that will see medical treatment provided from the time a claim is submitted, rather than from the date a claim is approved.[20]

5.17 The Government response to the NMHC report acknowledged the 'finding that many DVA clients have reported negative experiences' with DVA. It stated:

> DVA exists to serve our veterans and its clients. That is why in this year's Budget, the Government provided $166.6 million to implement the first stage of Veteran Centric Reform which is the most comprehensive upgrade to DVA systems, processes and technology ever undertaken.
>
> DVA's reforms will focus on:
>
> - Enhanced veteran experience - implementing an improved, easy access to veteran services, regardless of channel
> - Contemporary and modernised processes - our processes will be digital wherever possible, with fewer steps and shorter timeframes
> - Foundational ICT- updating ICT platforms to mitigate critical ICT risks for all business areas
> - Data driven approach - providing services to clients through proactive interventions and behavioural economics to deliver targeted assistance that will support veterans to lead healthy and productive lives.[21]

19 DVA, *Portfolio Budget Statement 2017-18*, p. 15.

20 DVA, *Portfolio Budget Statement 2017-18*, p. 18.

21 Government response to NMHC report, p. 8.

5.18 DVA outlined that it was also pursing improvements to claim processing through 'Lighthouse project'. This had the 'twin aims of improving *Military Rehabilitation and Compensation Act 2004* liability processing' and demonstrating DVA can deliver changes in line with the Australian Government's Digital Service Standard methodology and work collaboratively with public sector partners.[22] Mr Simon Lewis, the Secretary of DVA, told the committee:

> It will build on our success in implementing the digital transition agency's digital service standard into our project methodology through the Lighthouse project. This project redesigned the Military Rehabilitation Compensation Act, the MRCA, liability claims process with improved processing times for some claims reducing from 120 days to four days.[23]

5.19 These changes were achieving results in relation to reduced processing times. For example, Mr Orme from DVA described one initiative:

> The figure, when we first introduced non-liability health care, was approximately 53 days to deal with the non-liability claim. We got that down to 18, I believe, and currently we are running at 1.5 days per claim. That is a good example of the changed processes, the increase in training, the way we are doing our business differently and the way we are focusing on getting only the information that we need…[24]

ICT investment

5.20 Investment in updated ICT was a key focus of reform. The ASPC Capability Review in 2013 found:

> [T]here are some 200 individual ICT systems operating in the department with a dated desktop. Typically a client facing employee or assessor may need to open three or four separate applications, none of which 'talk to the other', in order to deal with a single client request or claim. Furthermore, staff or assessors may need to access additional separate applications (likely through another staff member) to determine if a client had a transport booking, or to check a client's eligibility for glasses or dental treatment.
>
> In the absence of a single client number or reference point, it is impossible for staff to see the full range of services that may be given to, or purchased for, an individual at any one point in time. This is somewhat ironic given the commitment of individual staff to their clients. Indeed, the array of disparate and ageing systems works against developing an integrated view of the client and is inconsistent with the principles of good client service. It creates a considerable number of legacy challenges for the department and tends to reinforce existing processes rather than encouraging more comprehensive process re-engineering to deliver more effective and efficient client services.[25]

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22 DVA, *Annual report 2015-16*, p. 11.

23 Mr Simon Lewis, *Committee Hansard*, Budget Estimates, 30 May 2017, p. 94.

24 *Committee Hansard*, 6 February 2017, p. 57.

25 APSC, Capability Review, p. 8.

5.21 The committee's report into the mental health of ADF members and veterans in 2016 recommended DVA be adequately funded to achieve full digitisation of its records and modernisation of its ICT systems by 2020, including the introduction of a single coherent system to process and manage claims. This recommendation was agreed in principle by the Australian Government which acknowledged that many of DVA's critical ICT current systems are out of date and in substantial need of modernisation.[26] It stated:

> Using existing resource allocations, DVA has already commenced a journey of digital transition with regard to paper records, which will take a number of years. In the last two years, DVA has also been reviewing its compensation claims processes and structures. Some streamlining of processes and organisational changes are bringing in improved performance. In addition, valuable work has been completed in analysing existing business processes and identifying future business processes.[27]

5.22 The urgent nature of this investment in ICT was underlined during the inquiry. For example, Mr Lewis, the Secretary of DVA, told the committee that 'the reality is that [DVA] have over 150 quite antiquated systems, over half of which the Finance department regards as being at—is it 'very high', or 'catastrophic'—risk of failure'.[28] The 2015-16 Budget included $23.9 million for DVA to commence a two-year program, known as the Improving Processing Systems (IPS) Program, to redesign and redevelop key rehabilitation and compensation (R&C) systems.[29] DVA noted:

> IPS is designed to improve the short-term capability and sustainability of critical ICT business applications that underpin compensation and rehabilitation processing systems, which have been assessed as having a high likelihood of catastrophic failure and are experiencing increasingly more frequent outages.[30]

5.23 DVA noted that the 'recent digitisation of correspondence and files, and planned implementation of a new claims processing system, will reduce DVA's dependency on paper'. Claims processing will be improved as staff 'will readily have access to the relevant electronic information and evidence'.[31]

5.24 Some of this investment has leveraged Department of Human Services (DHS) ICT capabilities and has been driven by broader government reform agendas in relation to welfare payment infrastructure. DHS has been provided with $68 million to develop new ICT capability for the DVA as part of Veteran Centric Reform.[32] The

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26 Australian Government response, p. 14.

27 Australian Government response, p. 14.

28 *Committee Hansard*, 6 February 2017, p. 50.

29 DVA, response to written question on notice 6 February 2017 public hearing.

30 DVA, response to written question on notice 6 February 2017 public hearing.

31 DVA, response to question on notice 27, Budget estimates, 30 May 2017, p. 1.

32 DVA, response to question on notice 5, Budget Estimates, 30 May 2017, p. 1.

Government response to the NMHC report highlighted a key initiative was the joint DVA and DHS 'MyService', an online service that allows clients who enlisted in the ADF after 30 June 2004 to submit a request for entitlements under MRCA online. It stated:

> Through MyService, the initial liability processing time for some claims has reduced from the key performance indicator of 120 days to only four days…While MyService only supports a small segment of the ADF and veteran population, it was developed to show that DVA can rapidly transform client services – now DVA and DHS are looking at ways to expand the service to help a wider range of clients. This includes exploring ways to use MyService for claims under the [VEA] and the [SRCA], as well as looking into the automatic acceptance of certain physical conditions based on the expected impacts of meeting the ADF's rigorous physical training requirements. These initiatives will assist DVA to process claims in a timely fashion...[33]

Common issues raised

5.25 DVA's most recent client satisfaction survey indicated that while older veterans or families who have an enduring relationship with DVA are largely satisfied, contemporary veterans and families were less satisfied. 83 per cent of veterans were satisfied with DVA overall, 6 percentage points below the result of the last survey in 2014. However, only 49 per cent of veterans who were under 45 years of age were satisfied and 31 per cent were dissatisfied.[34]

5.26 The committee also received an independent survey prepared by a veteran, Mr Angus Sim, which was conducted online and received almost 600 responses. The responses to the survey illustrated the range of problems veterans report experiencing with DVA. The survey also indicated that younger veterans, often with claims under SRCA and MRCA, were the least satisfied with their experiences. In particular, many indicated that in dealing with staff in DVA 'the process and treatment by the DVA' had resulted their accepted conditions getting worse.[35]

5.27 A number of common issues have been raised in submissions from individual veterans, advocates for veterans, lawyers and ESOs regarding their interactions with DVA and the administration of the military compensation schemes. These included:

- administrative and staffing issues;
- delays in claim determinations;
- medical assessments by contracted practitioners;
- incorrect payments;
- communication issues; and

33 Government response to NMHC report, pp 38-39.

34 Mr Simon Lewis, *Committee Hansard*, Budget Estimates, 30 May 2017, p. 93.

35 *Submission 297*, Attachment 1, p. 64,

- adversarial approaches to claims.

Administrative and staffing issues

5.28 Several administration and staffing issues were raised including:

- the level of staffing;
- the quality and training of staff;
- the spread of DVA functions; and
- inefficient administrative practices.

Level of staffing

5.29 Some submitters pointed to reducing staffing as a challenge for DVA in fulfilling its administrative functions. DVA currently has around 200 delegate claim assessors dealing with approximately 30,000 claims per year. The average case load for each delegate was 90 cases.[36] Sympathy was expressed for the work pressure on DVA staff in processing claims. For example, Dr Nick Ford commented that from his experience 'DVA case managers carry a massive case load of 100 to 180 cases, have little clinical training and are generally focused on only process and compensation issues'.[37]

5.30 Staffing in DVA has trended down in the last decade from 2,369 in 2006-07 to 1,986 in 2015-16. The DVA portfolio budget statement for 2017-18 estimated an average staffing level of 1,853.[38] Some, such as Mr Peter Thornton, pointed to a lack of staff as the cause of poor administrative outcomes. He recommended DVA be excluded from the efficiency dividend and frontline staff increased.[39] Mr Thornton stated:

> If the reader is searching for possible reasons as to why DVA claims processing has been lack-lustre over time, or that client engagement might have been seemingly tense at times, then look no further than poor staffing policies by Governments, which arbitrarily imposed 'Efficiency Dividends' and punitive staffing cuts on the DVA...[40]

5.31 Others highlighted a lack of continuity in staff responsible for processing claims.[41] The TPI Federation noted that many DVA staff are temporary and had little background knowledge of veterans' issues.[42] Mr Ken Parnell who assists veterans as part of the William Kibby VC Veterans Shed in South Australia described his 'biggest problem' as the changing of staff at DVA. He stated:

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36 *Committee Hansard*, 6 February 2017, p. 57.

37 *Committee Hansard*, 17 November 2017, p. 2.

38 DVA, *Portfolio Budget Statement 2017-18, Budget Related Paper No. 1.4B*, p. 22.

39 *Submission 335*, p. 15.

40 *Submission 335*, p. 15.

41 For example, Mr Raymond Kemp, *Committee Hansard*, 17 November 2016, p. 12.

42 *Submission 307*, p. 4.

> It is people leaving. A lot are retiring. A lot of the knowledge has retired recently, even in this state. Over the last four years of nine I have noticed a lot of contractors coming in. They are employing staff under contract. They have put them onto three- or six-month contracts. They begin to learn their job, and then they are gone; they are not re-employed. [43]

5.32 In a response to a question on notice, DVA outlined that in 2015-16, 'the retention rate for APS5 claims delegates in the Rehabilitation and Compensation group was approximately 93 per cent'. The reasons for staff separating during the financial year were; retirement, transfer or promotion within the Australian Public Service, resignation or end of employment contract.[44] APSC statistics indicate that overall the retention rate of ongoing employees at DVA in 2015-16 was 89.4 per cent.[45]

5.33 One area which had recently received an increased level of staffing was case coordination. DVA highlighted that the 2015-16 Budget had provided $9.6 million over four years to deliver a measure to increase the number of case coordinators and establishing the Coordinated Client Support (CSS) service model.[46] It noted:

> Case coordinators are provided for clients with complex needs who have caused or may be in danger of causing harm to themselves or to others. Case coordinators help at-risk clients with complex needs to navigate through DVA services and benefits to minimise the risk of self-harm. Coordinators provide a primary point of contact for clients and help them and their families to access other psychosocial needs outside the Department.[47]

5.34 Mr Craig Orme from DVA told the committee:

> Under our case coordination system, we had 33 additional FTE provided to the department, which we brought on board last year. They provide increased case coordination for clients who have complex issues—it could be health; it could be a range of other social issues or difficulties—to ensure we provide better support. [48]

5.35 DVA considered the program had 'been successful in its implementation to date, receiving more than 800 referrals in 2016, and currently supporting more than 700 clients with complex needs…'. This included a number of clients identified as requiring support through their separation from the ADF on medical or administrative grounds.[49] Several submitters regarded the additional coordinated client support staff as a positive development. For example, the Partners of Veterans Association of

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43 *Committee Hansard*, 17 November 2016, p. 27.

44 DVA, response to question on notice from 6 February 2017 public hearing.

45 ASPC, *Australian Public Service Statistical Bulletin 2015-16*, 2016, p. 45.

46 *Submission 156*, p. 7,14.

47 *Submission 156*, p. 14.

48 *Committee Hansard*, 6 February 2017, p. 60.

49 DVA, response to question on notice from hearing 6 February 2017.

Australia endorsed the funding over four years of the Coordinated Client Support (CCS) service model. It stated:

> The appointment of additional Case Coordinators from early this year is markedly improving the Department's support of veterans at risk of self-harming and who have complex cases that necessitate multi-agency coordination. We note that the Department has changed the claim registration process to facilitate the early identification of cases that require coordination. We also note the wide range of ways in which veterans can be referred for case coordination.[50]

Quality and training

5.36 A number of submissions from veterans recounted negative experiences or inappropriate conduct in dealing with DVA staff members. For example, Ms Tracie Cooke was a sergeant with the Australian Army. She outlined she had a number of common health conditions for veterans including tinnitus and hearing loss. She stated:

> I spoke to a supervisor one day because the bloke who rang me was so rude he was saying HELLO HELLO yelling it and then said yep what do you want. I thought they were there to do a job, but the supervisor said oh they have been under stress too many claims they look after about 50 people each…[51]

5.37 Avenues to redress problems with DVA staff members were often perceived as inadequate. The Victims Of Abuse In The Australian Defence Force Association considered that the 'mechanisms for dealing with complaints against employees who have an uncaring attitude or contractors who do not fully understand the Acts are limited' and involve DVA 'sitting in judgement on itself'.[52]

5.38 While DVA employs a large number of members with military experience, some DVA delegates were considered to lack an appropriate understanding of the realities of military service and this impacted compensation claims by veterans.[53] For example, Mr Rod Thompson, an advocate, provided a number of examples from his experience where DVA staff had fundamentally misunderstood the military context when injuries to veterans occurred. He noted 'daily misunderstandings of the veterans' military service cause many claims to be rejected initiating a long, costly and damaging appeals process costing both the veteran and the DVA financially and emotionally'.[54]

5.39 Inadequate understanding of the legislative framework and incapacity to understand medical reports and evidence were also identified amongst DVA staff. For example, Dr Catriona Bruce and others highlighted that non-medically-trained DVA

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50 *Submission 45*, p. 3.

51 *Submission 113*, p. 1.

52 *Submission 281*, p. 14.

53 *Submission 295*, p. 7.

54 *Submission 334*, pp 4-5.

delegates are required to extract information from medical assessments to make a determinations which 'leads to inaccurate assessments, and significant stress and long-term consequences for the individual'.[55]

5.40 Additional training for DVA staff was frequently proposed. For example, RANZCP recommended that the training of DVA staff could be improved with regard to:

- veteran-specific mental health issues;
- appropriate use of sensitive language; and
- the realities of clinical practice.[56]

5.41 While some submitters expressed criticism of DVA staff, many also highlighted their personal experiences with high-quality DVA staff members. For example, Mr Johnson clarified that he did not wish to 'denigrate all staff in DVA' in his submission noting that there were 'many highly professional, committed and diligent APS officers working tirelessly to effect changes from within'.[57]

Spread of administrative functions

5.42 The placement of administrative functions relating to claims in different areas was also criticised.[58] For example, Mr John Burrows, an advocate, considered that '[t]he recent change in the responsibilities of DVA State Offices and relocation of topical points of contact has created confusion and considerable disruption amongst the veteran community'. He noted:

> Prior to these changes, each state DVA Offices was a 'one stop shop' for all matters DVA and were in many regards easily accessible and locally focussed. Now many of those responsibilities and the support once locally available to Veteran communities and their families have now been relocated to DVA Offices in other States.[59]

5.43 Similarly, Mr Brian Briggs from Slater and Gordon Lawyers commented:

> The splitting of functions geographically without appropriate IT support means DVA staff lack appreciation of the total picture regarding a Veteran's case. This further adds to delays in processing, duplication in actions required to resolve claims and additional frustration and stress for the Veteran…
>
> Files continue to be shipped all over the country; one section may deal with liability before another considers incapacity and then another rehabilitation or treatment.

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55 *Submission 171*, p. 2.

56 *Submission 165*, p. 15.

57 *Submission 264*, p. 9.

58 For example, Mr Robert Bak, *Submission 248*, p. 4.

59 *Submission 189*, Supplementary Submission, p. 10.

> Permanent impairment and compensation will be looked at by entirely separate teams. This entire bureaucratic file shuffling and passing on of an injured members' claim, causes significant delays. The frustration of my clients at this inefficiency and ineptitude is overwhelming.[60]

5.44 RSL (Tasmania) reported that its advocates had noticed an increasing lack of coordination between different life-stages of a claim since the reallocation of tasks between DVA offices in each state. It stated that while 'clustering claim functions into single silo sites may have been intended to introduce consistency of decisions, it has resulted in inefficiencies between claims stages, increases costs and increases frustration in veterans'.[61] It stated:

> Where a claim is made under MRCA or SRCA, liability for the claim is determined in either Melbourne or Sydney. Once liability is determined, Needs Assessment is performed in Adelaide, and then Incapacity payments or Permanent Impairment payments are assessed in Perth. In the past, where the Needs Assessment identified a need for both incapacity payments and permanent impairment claims, there was a degree of coordination between these phases of the claim in that specialist reports requested by the incapacity team were of a nature that addressed the needs of the permanent impairment team as well. Increasingly, this is not the case…[62]

Inefficient administrative practices

5.45 Many stakeholders involved in interactions with DVA including veterans, advocates and health providers highlighted confusing administrative practices and the negative impacts of cumbersome forms and paperwork. Mr Arthur Ventham illustrated these issues by noting that 'twelve years after the most recent Act was brought in, there is still no single claim form for veterans to fill out if their service cuts across multiple acts'.[63] He argued:

> DVA needs to simplify the overall MRCA and SRCA claims process. The complexity of MRCA and the extended investigations into the range of entitlements (Permanent Impairment, Incapacity and Rehabilitation) must be simplified to become less confusing so it is more easily understood by those it is designed to assist, particularly when they are suffering from a mental health condition.[64]

5.46 Similarly, Dr Jonathan Lane stated:

> [I]n in terms of claims for compensation or liability, there is an enormous amount of paperwork and administration involved in submitting a claim, along with the burden of proof required for this. Each individual injury or problem requires a separate claim form, regardless of whether they are

60 *Submission 148*, p. 5.

61 *Submission 169*, p. 16.

62 *Submission 169*, p. 14.

63 *Submission 295*, p. 13.

64 *Submission 295*, p. 10.

> related injuries. Each claim may be many, many pages long. That claim may then be assessed by somebody with only superficial knowledge of the issues involved, and hence rejected, as the claim was not clear, or not understood by the assessing psychiatrist. These problems are exacerbated by the claimants not understanding what is going on with themselves at the time, and the fact that they are quite obviously unwell when undergoing this process.[65]

Delays

5.47 A key complaint in relation to DVA's administration related to lengthy delays in the processing of claims. The DVA client satisfaction survey noted that veterans under 45 years were much more likely to have submitted a claim to DVA in the last 12 months (37 per cent) compared to older veterans. There were stark differences between older and contemporary veterans in terms of satisfaction with the time taken to process a claim or application. While 65 per cent of veterans 65 years and over were satisfied, only 56 per cent of those aged 45-65 years and 39 percent of those aged under 45 years were satisfied.[66]

5.48 The toll of administrative delays on claimants was repeatedly made clear. For example, the committee spoke to Mr Guy Bowering, who despite having a relatively clear cut condition and accurate records waited three and a half years for his claims to be finalised. He noted that he knew of veterans for whom the process was too hard and withdrew their claims.[67] The joint submission from Dr Catriona Bruce and others noted that delayed claim processes leave the individuals 'in a form of limbo which directly and negatively affects mental health' and can also cause 'severe financial distress to individuals, which is a causative factor for suicide'.[68]

5.49 DVA provided information on claims under the three schemes and the average time taken to process (TTTP). The average TTTP VEA compensation cases in 2015-16 was 72 days, the same as in 2014-15, against a target of 75 days.[69] DVA indicated that, as at 6 February 2017, the oldest liability claim under the VEA was 440 days old. The delay in finalising this claim was due to the time taken to obtain medical evidence, from the applicant's treating general practitioner and treating psychiatrist, for the multiple conditions claimed across all three Acts.[70]

5.50 In 2015-16, 5,920 compensation conditions were determined under the SRCA, with an acceptance rate of 60.9 per cent, and the mean time taken to process SRCA liability cases was 118 days.[71] The average TTTP in 2014-15 was 140 days with a

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65 *Submission 78*, p. 1.

66 DVA, *2016 Client Satisfaction Survey*, May 2017, p. 17.

67 *Committee Hansard*, 17 November 2016, pp 42-43.

68 *Submission 171*, p. 1.

69 DVA, *Annual report 2015-16*, p. 39.

70 DVA, response to question on notice from 6 February 2017 public hearing.

71 DVA, *Annual report 2015-16*, p. 49.

target of 120 days.[72] DVA indicated that, as at 6 February 2017, the oldest liability claim was a SRCA claim which was 536 days old. The delay in finalising this claim was due to the time taken to obtain medical evidence from the applicant's treating general practitioner and treating specialist. The claim was subsequently finalised.[73]

5.51 In 2015-16, 14,527 compensation conditions were determined under the MRCA, with an acceptance rate of 71.4 per cent, and the mean time taken to process MRCA liability cases was 117 days.[74] The average time taken for 2014-15 was 109 days with a target of 120 days.[75] DVA indicated that, as at 6 February 2017, the oldest liability claim under the MRCA is 484 days old. This relates to a claim for compensation following death. The delay in finalising this claim is due to the coroner's investigation not yet reaching a conclusion on the cause of death. This claim will be finalised once the Coroner's Court has made a decision on the cause of death.[76]

5.52 However DVA and others submitters emphasised that delays can also be the result of processes occuring at other agencies. For example, Mr Rod Thompson, an advocate noted that the 'Commonwealth Superannuation Corporation…are running at least 9 months behind in processing assessments'.[77] Mr Lewis, the Secretary of DVA, stated that some veterans with medical discharges could be 'waiting a lot of time for the CSC to make its determination, and the DVA cannot start to make its determination until it knows the outcome of the CSC'. He noted that meetings were occurring between CSC, DVA and Defence 'trying to work out ways to get the system to work much better in relation to someone who will be going through the medical discharge process with a view to getting the CSC determination and then hopefully the DVA determination, and ideally all of that before the point of discharge'.[78]

5.53 The 2017-18 Budget included funding of $13.5 million for one year to alleviate pressure on claims processing staff and to reduce the backlog associated with increasing claims.[79] DVA budget documents acknowledged that 'increased claims processing workload has placed significant pressures on the [DVA's] ability to effectively deliver services to veterans'. The measure will enable DVA to maintain the necessary workforce and resources to help meet increased workloads and reduce the claim backlogs.[80]

5.54 Various proposed solutions were suggested to address the backlog in claims. Some proposed a DVA taskforce or dedicated section to expedite assessment and

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72 *Submission 156*, p. 18.

73 DVA, response to question on notice from 6 February 2017 public hearing.

74 DVA. *Annual report 2015-16*, p. 49.

75 *Submission 156*, p. 18.

76 DVA, response to question on notice from 6 February 2017 public hearing.

77 *Submission 334*, p. 3.

78 *Committee Hansard*, 6 February 2017, p. 56.

79 Mr Simon Lewis, *Committee Hansard*, Budget Estimates, 30 May 2017, p. 93.

80 DVA, 'Improving claims processing', *Budget 2017-18*, p. 1.

processing of all outstanding claims.[81] Others suggested new processing benchmarks and service level standards to ensure more timely processing of claims. For example, DiggersRest@Quailsridge, a small ESO, suggested 'DVA should have a set time frame to process these claims and be held accountable should they not process the claim on time. In particular, veterans should get automatic approval of claims if they are not processed within the time period.[82]

5.55 Mr Brian Briggs, from Slater and Gordon Lawyers proposed the introduction of 90 day time limits on:

- decisions in relation to acceptance or refusal of liability for claims;
- decisions in relation to compensation; and
- reconsideration of original determinations.[83]

5.56 Under this proposal, if decision is not made within the specified time frame, the claim should be deemed to have been rejected and the claimant able to apply for reconsideration or review. Mr Briggs argued that several other overseas jurisdictions incorporated time limits into their claims processes for veterans and this had led to increased efficiency and better outcomes. He noted that DVA has previously refused to incorporate such amendments.[84]

5.57 Notably, the NMHC report recommended:

> As DVA has mapped the process between lodging a DVA claim, acceptance of a claim, and first payment being made, and established key performance indicators for the time to decision and payment, it should implement a default position, in the event that a decision is not made within the stipulated timeframe, to pay a claimant until such time as a definitive decision is made. This provides an impetus for DVA to ensure that claims are processed in a timely fashion and that claimants are not unreasonably disadvantaged by delays in DVA administrative processes.[85]

5.58 However, the Government response stated:

> While the Government is committed to reducing Time Taken to Process claims and improvements have already been made in recent years, the Government does not support a default position in the event a decision is not made within a stipulated timeframe. Legislated timeframes for the processing of initial liability claims under the *Military Rehabilitation and Compensation Act 2004* were the subject of the Review of Statutory Timeframes report tabled in Parliament in June 2014. The report recommended against the introduction of legislated timeframes because

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81 For example, Mr Ben Johnson, *Submission 264*, p. 6.

82 *Submission 275*, p. 1.

83 *Submission 160*, p. 25.

84 *Submission 160*, p. 25.

85 NMHC report, p. 54.

> they increased the risk of poor, incomplete or incorrect outcomes for claimants.
>
> In any case, a number of major initiatives through the Veteran Centric Reform project will result in reduced time taken to process claims.
>
> Veterans can access treatment for any mental health condition without the need for a compensation claim through Non-Liability Health Care arrangements.[86]

5.59 ADSO noted that the review of statutory timeframes had identified a range of factors which contributed to delays. These included:

- the investigative nature of the claims process;
- the time between incident and lodgement of a claim;
- the complexity of claims;
- the receipt of incomplete claims; and
- the involvement of external parties, such as the Department of Defence (Defence) and medical providers, in the claims process.[87]

5.60 However, the ADSO highlighted that there were positive improvements in processing times arising from recent reforms which had streamlined claims processing under both the VEA and MRCA. It reiterated the importance of further appropriations to DVA to enable further Lighthouse Project reforms to improve claims processing.[88]

Medical assessments

5.61 Serious complaints were raised regarding the quality, appropriateness and fairness of medical assessments required by DVA in the claims process. DVA outlined that its departmental guidelines state that a report from a treating specialist is preferred, however it noted that it may use external, non-treating medical practitioners (often a medico-legal firm) to seek an independent report in some cases. These medico-legal companies are selected on a case by case basis and there is no schedule of fees or contract and payment is on a case by case basis. These medico-legal firms were used in situations where:

> - the client does not have a treating specialist or, more rarely, where the delegate is dissatisfied with the treating doctor's response e.g. there is conflicting information;
> - insufficient information is provided with the claim and it is necessary to ask the client to undergo a medical examination e.g. to determine the level of impairment, the deterioration and/or the permanency of the condition;

86 Government response to the NMHC report, p. 71.

87 *Submission 172*, p. 12.

88 *Submission 172*, p. 11.

- the treating specialist cannot or will not provide the required information; or cannot provide it in a timely manner;
- a subsequent report still does not meet the diagnostic criteria;
- a report is deficient in some aspect and a report from a further medical professional is required for the purpose specified in the referral.[89]

5.62 However, RSL Tasmania reported that its advocates were finding DVA's policies were 'often not adhered to'. It stated that '[i]n many cases, a claimant has a treating specialist, and these details have been provided to the delegate, but the treating specialist is not used and, instead, an MLCOA specialist is used'. It outlined a number of issues with the use of independent specialists. In particular:

> A further difficulty with using independent specialists in preference over treating specialists is that claimants may not be comfortable speaking with an independent in some circumstances. This is particularly the case when dealing with mental health claims where trust between the patient and the specialist is an essential element in both accurate diagnosis and treatment…Treating specialists have had time to overcome this and have a much clearer picture of the claimant's mental health than can be provided by an independent in a relatively short, single consultation.[90]

5.63 Many veterans reported difficulties in accessing appointments for medico-legal assessments and objected to another opinion being sought when one was available from their own treating specialist. ADSO considered there was evidence that 'too many Independent Medical Examiners and Approved Rehabilitation Program Providers approach their contracted responsibilities as though veterans are compensation insurance claimants from the general community – with all the associated pejorative connotations'.[91] One veteran described attending appointments arranged by DVA as 'extremely stressful for veterans and families'. They commented:

> There is no patient Dr relationship, nor period of observation to facilitate a balanced or fair assessment. There is no reason that the Department should not accept the assessment of the GP or specialist, provided by the veteran, with whom the veteran has established some trust within a clinical relationship.[92]

5.64 Ms Michelle Roberts related her husband's experience:

> My husband was sent to a MCLOA Dr in December 2014. We drove 3 hours on a Saturday with our children for the appointment. We had trouble finding the place so rang to say he was going to be 15 minutes late. Even so, the doctor told him off when he arrived. The doctor refused to look at any medical documents my husband had brought with him, instead relying on only the x-rays Defence had provided. The extent of my

89 DVA, response to written question on notice 6 February 2017 public hearing.

90 *Submission 169*, p. 8.

91 *Submission 172*, p. 14.

92 Name Withheld, *Submission 292*, p. 5.

> husband's injuries is not able to be seen in x-ray. The whole appointment lasted 15 minutes…[93]

5.65 The TPI Federation questioned the cost of legal work and health reports when a veterans' condition is obviously Defence caused, and is referred to in the Defence medical documents.[94] It observed that DVA has acknowledged that there are less than 1.5 per cent of claims that are disingenuous. In this context, the TPI Federation suggested that DVA should change its approach to accept a claim for compensation and medical health and allow the few disingenuous claims to be followed up by DVA's fraud section. This would mean that the vast majority of clients 'need not be put through the wringer to prove a case with very expensive medical reports and, at times, legal reports'. It recommended DVA accept veterans face-value and 'not treat them as potential fraudsters'.[95]

5.66 Dr Andrew Khoo agreed that there are examples of inappropriate medico-legal assessments of veterans:

> [T]here is a belief that the treating psychiatrist will consciously or unconsciously overadvocate for their patient in a way that will skew their opinion in terms of how sick that person is. That is why they want to get an independent view. You cannot get the same picture about what is going on with someone at that time, how they are going to respond to treatment and what their prognosis is in the future, if you have not been regularly seeing that person in a longitudinal fashion. You are going to get a much more definitive and a much more reliable, valid picture of a person's medical position at that time and their prognosis in the future, if you get their treating psychiatrist to write the report rather than an independent that might see them, like you say, for 45 minutes and then make all those broad statements.[96]

5.67 He noted that these independent medical examinations could destabilise patients by causing them to repeatedly talk through difficult circumstances, promoting distrust, adding delays to claim processing and 'personalising the diagnostic position of the independent medical examination…seeing [the patient] as a liar or someone who is fabricating a story'.[97] Similarly, Dr Jonathan Lane, a psychiatrist, also questioned the value of short assessments for mental health conditions:

> A person actually often will appear better than what they really are in that one-off assessment because they do not have the chance to be able to display the range of symptoms they have got, the severity of the symptoms

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93 *Submission 314*, p. 2.

94 *Submission 307*, p. 6.

95 *Submission 307*, pp 6-7.

96 *Committee Hansard*, 2 February 2017, p. 11.

97 *Committee Hansard*, 2 February 2017, p. 11.

> and the duration of those symptoms…It is traumatising for the person, and it is actually underrepresenting their true level of debility, mostly.[98]

5.68 However, there were contrasting positions. Mr Peter Reece recommended 'all medical assessments for permanent disability be conducted by expert contracted medicos, not by veterans' own GP's. He considered more 'rigour' was required 'especially in mental health assessments'.[99]

5.69 The Government response to the NMHC report noted that '[i]n order to access services from CSC and DVA, members are often required to undergo further medical assessments and provide additional medical information'. It acknowledged that '[t]his can cause frustration for separating members when they feel they have to undergo multiple medical assessments for the same conditions and provide the same information a number of times'.[100] It highlighted:

> Defence, DVA and CSC are working together to improve the health examination process at the time of separation from the ADF. A Single Medical Assessment Process (SMAP) will be more member-centric, reduce the requirement for multiple medical assessments where possible, and avoid the requirement for the member to submit the same information more than once.[101]

Incorrect payments

5.70 Several veterans highlighted issues they had experienced relating to incorrect payments being made by DVA.[102] Mr Michael Quinn, an advocate, commented:

> The department states that because there is less than a 3% over payment problem that this does not require attention. The problem is that if you fall within the 3% you can end up owing the department tens of thousands of dollars. This [is] unacceptable if you are waged capped at 75% of a Privates wage. The mistakes tend to reoccur to the same veteran and provide a great deal of distress.
>
> The main problems seem to occur when providing offsetting calculation between ComSuper and Incapacity payments. This problem is exasperated even further when the Tax is being calculated. It is very difficult to find someone within the department to find the error and even when all criteria are met for the debt to be written off it very rarely occurs. The issue of overpayments needs investigating in it own right. There are no efforts being made to fix the problem. An over payment issue can remain with the veteran for 2 or 3 years. In some cases the repayment will take decades.[103]

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98 *Committee Hansard*, 17 November 2016, p. 19.

99 *Submission 378*, Supplementary submission, p. 2.

100 Government response to the NMHC report, p. 32.

101 Government response to the NMHC report, p. 38.

102 For example, Ms Ashley Smith, *Submission 26*, pp 1-3, Slater and Gordon Lawyers, *Submission 160*, p. 38, Name withheld, *Submission 306*, pp 1-11.

103 *Submission 29*, p. 4.

5.71 Where two or more agencies were involved in incorrect payments the potential problems for the veterans appeared to be amplified. For example, the TPI Federation outlined an issue where a 'non-operational DVA client who HAS to deal with Centrelink is advised by them that there is an overpayment':

> This needs to be repaid via the Centrelink Disability Pension. Because there was an overpayment with this payment then the [Defence Force Income Support Allowance (DFISA)] from DVA also has an overpayment. This has to be recovered from the DFISA payment. If a DVA client wants to query this overpayment, then Centrelink advise that DVA should be contacted and then DVA advise that Centrelink should be contacted. There is never a resolution. Again, DVA should be controlling all DVA client's payments. With this type of confusion there is much to worry about with those DVA clients who have mental health issues.[104]

5.72 Mr Brian Briggs from Slater and Gordon Lawyers considered that incapacity payments in particular were not well managed by DVA. He noted that the 'ANAO provides that in 2014, the DVA reported that over 20 per cent of payments were made in error or were instances of overpayment'.[105]

5.73 DVA outlined that it was legislatively bound to administer debts and overpayments across the three legislative schemes and that if clients were paid more than they are lawfully entitled to receive, those monies were recoverable debts. It noted:

> The majority of overpayments are for relatively small amounts and occur when clients do not meet their obligations to advise DVA of changes in their circumstances or, they no longer meet the specific eligibility requirements for a certain benefit. Changes in a client's circumstances can mean that they are entitled to either a higher or lower benefit. When an overpayment occurs, a repayment plan is developed based on the client's capacity to repay the debt.
>
> Aged clients who experience large pension reductions and have no representative are contacted by telephone before receiving written advice from the Department. There are also guidelines for staff to follow for contacting clients with mental health conditions who have overpayments. Recovery is always within the client's capacity so they are not adversely affected. Clients are able to contact DVA if they have difficulties in repaying an overpayment.
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> While most overpayments are recovered, in certain circumstances some are waived or written off.[106]

5.74 DVA listed a range of processes and strategies used to ensure that its clients were receiving correct entitlements. These included:

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104 *Submission 307*, p. 4.

105 *Submission 160*, p. 38.

106 DVA, response to written question on notice from 6 February 2017 public hearing.

- a booklet for new income support pension clients and periodic letters to inform and remind them regarding their rights, benefits and legal obligations;
- publication of DVA factsheets concerning client obligations in regard to specific circumstances or issues; and
- an extensive Quality Assurance Program which monitors the quality and consistency of decisions and determinations made.

5.75 DVA stated that '[t]o complement these strategies, there are departmentally driven control activities in place which include departmental initiated reviews (e.g. enhanced compliance reviews, periodical payment or medical reviews), identity checking and data-matching programs with other Government agencies (e.g. death data matching)'.[107]

Availability of information and communication

5.76 One advocate, Mr John Burrow, described unrealistic expectations in the military community regarding the availability of some benefits as well as a ' systemic failure within the DVA organisation…that many veterans, families and dependants do not understand what is available, who can help, identifying what's needed and obtaining the appropriate support to meet those needs'. He noted that there are very few sources willing or able to provide information on eligibility or 'a detailed description of entitlements and available benefits and then define the complexities of accepting various benefits and support'.[108]

5.77 Similarly, the RSL considered that 'DVA needs to significantly improve how it explains the overall MRCA and SRCA claims process'. It stated:

> The complexity of MRCA and the extended investigations into the range of entitlements (Permanent Impairment, Incapacity and Rehabilitation) are extremely opaque and therefore not able to be easily understood by those it is designed to assist, particularly when they are suffering from a mental health condition.[109]

5.78 A submission from a veteran who requested to be anonymous commented that a '[v]eteran whom may be suffering from a myriad of problems let alone mental illness can have great difficulties trying to find what they may be entitled to on the DVA website'. He suggested information 'needs to be placed in layman's terms and perhaps certain scenarios and flow charts put in place'. He stated:

> DVA needs to make this process easier for a veteran to decipher because they look at the website and think 'This is all too hard its doing my head in!' And don't get the help they are entitled to receive.[110]

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107 DVA, response to written question on notice from 6 February 2017 public hearing.

108 *Submission 189*, Supplementary submission, pp 3-4.

109 *Submission 216*, p. 11.

110 Name withheld, *Submission 302*, p. 6.

5.79 It was apparent during the inquiry that many contemporary veterans prefer to seek and discuss available support services on social media or email groups. For example, witnesses and submitters often referred to discussion on closed online discussion groups. ADSO underscored the need for awareness programs, pointing out that knowledge of available support services in the veteran community could not be assumed:

> ADSO monitors a significant number of social media sites frequented by younger veterans and their families. That exercise reveals that few are aware of the information available on either the Defence Community Organisation website or in DVA's Factsheets.[111]

5.80 However, a name withheld submission noted that many DVA clients received helpful advice from various closed Facebook groups. To reflect this he suggested the 'official DVA Facebook page needs some serious expansion, and more open and honest 2-way discussion'.[112]

5.81 Mr Max Ball also argued that DVA's communications and stakeholder engagement areas were not being proactive in monitoring and addressing issues raised in the veteran community. He illustrated this concern with an example of a widely circulated allegation against a DVA service. He stated:

> My immediate concerns over this allegation included that this email itself could cause stress amongst some veterans, that it should be investigated immediately and that the department should respond with alacrity to the veteran community on this matter, not with 'spin', but in a way that reflects public relations skills as compared to communication skills.[113]

5.82 RSL Tasmania highlighted a spectrum of DVA communication issues relating to clients and advocates. These included:

- excluding advocates from communications regarding veteran clients, particularly complex assessment surveys;
- leaving advocates to communicate adverse determinations to 'difficult' claimants; and
- poor quality determination letters containing 'little by way of reasoning'.[114]

5.83 The quality of correspondence was also highlighted by the TPI Federation which described some DVA correspondence as 'confusing, ambiguous and too legalistic'. It considered that this was an area to be addressed urgently. At the hearing, Ms Pat McCabe, President of the TPI Federation, indicated that DVA may be looking at the issue as part of the Project Lighthouse initiatives.[115]

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111 *Submission 172*, p. 6.

112 *Submission 306*, p. 2.

113 *Submission 323*, Supplementary submission 2, p. 3.

114 *Submission 169*, pp 16-20.

115 *Committee Hansard*, 5 May 2017, p. 26.

5.84 A common problem appeared to be DVA not registering or consistently using the advocates or lawyers nominated by veterans as their authorised representatives. For example, DFWA (Qld) cited repeated cases of delays in processing applications 'due exclusively to DVA contacting the Veteran direct and not using the Veteran's Authorised Representative (AR)'. It commented that it 'appears that DVA staff lacked visibility of the Veteran file due to its physical location interstate and inadequate IT support'.[116]

5.85 Examples of unreasonable, insensitive or inflexible approaches by DVA in communicating with veterans were also given in evidence. For example, Mr Peter Larter told the committee about a veteran he was assisting who had a diagnosis that was linked to service, but who had submitted his claim under the wrong scheme:

> He can put a claim in under the VEA, but actually the injury in the diagnosis was under the MRCA. The letter that he receives back—I know this verbatim I have seen it that many times—goes along the lines of, 'Your condition of PTSD is not related to service.' That is almost in the first paragraph and that is the decision. How do you think that member feels right now?[117]

Adversarial approach to claims

5.86 A number of submitters and witnesses argued that DVA had developed an adversarial approach to claims by veterans.[118] This stance towards claims was considered inappropriate given the beneficial nature of the legislation for veterans being administered.

5.87 Often veterans described DVA as acting like an 'insurance company' in relation to claims by veterans with internal pressure on DVA staff to downgrade the severity of conditions.[119] RSL Tasmania thought that 'many of the delegates within the DVA who consider liability for claims lodged [under SRCA and MRCA]…approach the claims from a perspective similar to that used by assessors of insurance companies, and assess claims with a view to avoiding liability, rather than applying the principles underpinning beneficial legislation'.[120] Mr Raymond Kemp stated that his belief was that 'the vast majority of DVA delegates try their best reject the claim at the primary level'.[121] He stated:

> The adversarial approach leads to unnecessary stress on the veteran and also unnecessary costs to both the department and veteran. The VEA is meant to be beneficial legislation, however delegates go out of their way to be difficult…It seems to me minor disabilities are accepted without any

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116 *Submission 148*, p. 4.

117 *Committee Hansard*, 5 May 2017, p. 15.

118 For example, Mr Guy Bowering, *Committee Hansard*, 17 November 2017, p. 39.

119 For example, Northern Suburbs Veterans Support Centre, *Submission 279*, p. 1.

120 *Submission 169*, pp 2-3.

121 *Submission 201*, p. 2.

> problem; however, the more serious ones are normally rejected at the primary level.[122]

5.88 Mr Kemp recommended that 'if a claim is to be rejected then a face to face arbitration session should be held between the delegate, his senior, the client and his advocate'. He noted that this should save money 'if the claim is then settled at that point'.[123]

5.89 Mr Rod Thompson thought this was a change departmental behaviour:

> The DVA since approximately 2010 have taken an adversarial approach to veterans across all areas of departmental responsibility purely to save money and limit liability, implementing policy designed only to delay and deny liability and compensation. When the issues are raised by complaint or through ESORT or other established channels the matters are dismissed, buried or in some cases handed to outsourced Law Firms with expertise in corporate damage control to snow over some very questionable behaviour by the Department.[124]

Compensation for Detriment Caused by Defective Administration (CDDA)

5.90 The CDDA scheme provides a mechanism for compensation where a person has suffered detriment due to the defective actions or inaction of the Commonwealth Government. The CDDA Scheme is an administrative, not a legislative scheme. The responsibility for determining CDDA claims rests with the portfolio Minister and officers authorised by the Minister. Payments made under the CDDA Scheme are discretionary. This means there is no automatic entitlement to a payment.[125]

5.91 DVA's view was that it had a 'good record and has made significant improvements over time in dealing with claims under the CDDA Scheme'. During 2015-16, a total of $70,485.74 was paid by the DVA in compensation under the CDDA Scheme. DVA received 28 claims under the scheme in 2015-16. Of these the Secretary of DVA found defective administration occurred in seven cases.[126] DVA clarified:

> The number of claims received by the Department should be put into context with the overall number of decisions made by DVA. For example, rehabilitation and compensation delegates make more than 40,000 decisions a year and income support delegates make more than 50,000 decisions a year.[127]

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122 *Submission 201*, p. 4.

123 *Submission 201*, p. 5.

124 *Submission 334*, pp 7-8.

125 Department of Finance, The Scheme for Compensation for Detriment caused by Defective Administration (CDDA Scheme),

126 *Submission 156*, p. 39.

127 *Submission 156*, p. 40.

5.92 However, the committee received several submissions, including confidential submissions, which expressed dissatisfaction with CDDA as a mechanism to obtain compensation for defective administration by DVA and Defence.[128] A name withheld submission made the point that that rectifying administrative errors by DVA can involve 'unrecoverable accountancy costs and lost interest recovery on the underpayments, even if the cause of it all meets the requirements under CDDA'.[129] Further, Mr Alan Ashmore commented:

> Veterans who lodge a CDDA claim against DVA have almost no chance of success because:
>
> - The approval of such claims is at the discretion of DVA.
> - Where DVA reject a CDDA claim and the Veteran has the Commonwealth Ombudsman decide in the Veterans favour, DVA are not required by law to follow the Ombudsman's recommendation, and,
> - Even when there is clear evidence of defective administration DVA will deny it, but instead will often acknowledge the case could have been better handled.
>
> This means the Veteran has virtually no chance of seeking justice for what the VRB and other appeal bodies determine are either clear errors or negligence on the part of DVA, or a combination of both. This makes a mockery of current and previous Prime Ministers promising to look after Veterans when they return not to mention the motto on DVA letterhead, 'Saluting their Service'.[130]

5.93 Maurice Blackburn Lawyers noted that the 'overarching principle of the CDDA scheme is to restore claimants to the position they would have been in had the defective administration not occurred'. It proposed that when 'assessing damages to determine the appropriate level of compensation, common law principles of the assessment of damages ought to be applied'. Further 'there should be allowance for the payment of legal costs and disbursements to provide assistance for claimants to prepare their CDDA application at 100% of the Federal Court of Australia's Scale of Costs'.[131]

Conclusion

5.94 Amongst the agencies of the Commonwealth Government, DVA is one of the oldest and most stable departments. However, the overall impression the committee received during the inquiry was that DVA administrative capabilities have been gradually run down over a significant period. Reduced levels of staffing, the impact of the efficiency dividend and a lack of investment in efficient ICT has had an increasingly negative impact on the administration of claims by veterans. Over time

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128 For example, Dr Phoebe Donaldson, *Submission 128*, p. 1.

129 *Submission 306*, p. 3.

130 *Submission 87*, p. 3.

131 *Submission 451*, p. 15.

piecemeal reform in the portfolio has often resulted in additional complexity rather than streamlining administration. At the same time, a gradually changing client base of veterans has imposed additional stresses on the workload of DVA.

5.95 The evidence to the inquiry indicates some urgent areas for administrative reform identified by Professor Dunt in 2009 and by the APSC Capability Review in November 2013 have not been adequately addressed. In this context, recent appropriations by the Australian Government to support major transformative change are welcome. Important administrative reform is starting to occur, but the pace does not reflect the importance of the outcomes for veterans and their families.

5.96 Perhaps the most concerning evidence the committee received related to veterans who gave up their claims in frustration before they had even received a final determination due to their adverse experiences in the administration of their claims. A number of veterans (and partners of veterans) explained that they would not speak or engage with DVA staff again due their negative experiences.

5.97 Recent improvements by DVA highlight the potential of further reform to administrative processes. The committee recognises that this transformation process will require time and substantial resourcing. Accordingly, the committee urges the Australian Government to continue funding future appropriations to ensure the next stages of the DVA reform program are undertaken in a timely manner.

5.98 In particular, the committee reaffirms its recommendation that DVA be adequately funded to achieve full digitisation of it records and modernisation of its ICT systems by 2020, including the introduction of a single coherent system to process and manage claims.

Recommendation 7

5.99 The committee recommends that the Australian Government continue to support the 'Veteran Centric Reform' program within the Department of Veterans' Affairs.

5.100 The committee considers that the interim measures to assist with claims processing should be continued and expanded until the benefits of the Veteran Centric Reform can be fully implemented. In particular, the budget initiatives to alleviate pressure on claims processing staff and to reduce the backlog associated with increasing claims and to increase the number of case coordinators should continue. If significant benefits for clients are derived from these measures, consideration should be given to expanding them further.

Recommendation 8

5.101 The committee recommends that, while the Veteran Centric Reform program is being implemented, the Australian Government continue to fund measures to:

- **alleviate pressure on claims processing staff and to reduce the backlog of claims; and**
- **increase case coordination staff to assist clients with complex needs.**

5.102 Maintaining high client service standards is a constant issue in any department where there is a turnover of staff or where non-ongoing staff are employed. DVA also faces this challenge. Given the concerns raised regarding the conduct and expertise of DVA staff in submissions to the inquiry, the committee considers DVA should re-examine its training programs directed to delegates and those other staff dealing with veterans making claims for compensation and rehabilitation.

Recommendation 9

5.103 The committee recommends that the Department of Veterans' Affairs conduct a review of its training program to ensure relevant staff:

- **have an understanding of the realities of military service;**
- **have an understanding of health issues of veterans;**
- **have appropriate communication skills to engage with clients with mental health conditions; and**
- **have sufficient training to interpret medical assessment and reports.**

5.104 The committee supports the efforts by DVA, Defence and CSC to implement a Single Medical Assessment Process to minimise situations where veterans are required to attend multiple medical appointments. Many veterans were dissatisfied with their experiences at medio-legal firms. Several objected to being required to attend appointments with a medical practitioner who was not their own treating specialist. In the view of the committee, DVA needs to reassess its use of medico-legal firms to ensure that these assessments being contracted are appropriate for the conditions of veterans, particularly in the case of mental health conditions.

Recommendation 10

5.105 The committee recommends that the Department of Veterans' Affairs review its use of medico-legal firms in relation to the assessment of the conditions of veterans. In particular, this review should confirm:

- **assessments undertaken are appropriate to the conditions considered;**
- **that the medical professionals used have undertaken training on treating veterans and can demonstrate their expertise working amongst this client group; and**
- **the need for independent medical assessments where information is already available from the veteran's own doctor or treating specialist.**

5.106 DVA should also take the opportunity to review its communication strategies and awareness raising activities concerning services and benefits available to veterans. The diverse nature of the veteran community is a challenge. While older veterans are not reliant on online resources, contemporary veterans expect online resources to be available. In the view of the committee, there is room for DVA to enhance its digital communications through social media to reach younger veterans. Proactive and responsive engagement online can operate to identify current issues and direct veterans to the most appropriate resources and correct circulated information which is misunderstood or incorrect.

Recommendation 11

5.107 The committee recommends the Department of Veterans' Affairs expand its online engagement with younger veterans through social media to raise awareness regarding available support services.

Independent administrative review

5.108 The NMHC's report recommended that the 'Australian Government should commission an economic study of the current expenditure (within Defence, Veterans' Affairs, Health, Human Services and Social Services) on health, welfare and disability support for current and former Defence personnel and their families, and consider whether there are superior models for supporting optimal health and wellbeing of current and former members and their families, including models that separate compensation, liability and health care provision'.[132]

5.109 However, the Government response stated:

> The link between compensation and health care for mental health conditions has already been separated through the provision of non-liability heath care under DVA arrangements. Given this separation and other Budget 2017 initiatives of pro-active intervention, the proposed economic study would have limited value. DVA and Defence are focussing on wellbeing and participation models that are acknowledged as leading to better outcomes for members and veterans.
>
> The Australian Government Actuary annually estimates the liability of the SRCA and MRCA schemes.[133]

5.110 Broad ranging proposals for reviews of administrative issues relating to veterans were made by submitters during the inquiry. For example, Dr Catriona Bruce and others recommended the '[i]nstigation of a Productivity Commission review of the administrative affairs of DVA with a focus on efficiency, wasted administrative funding, cost-effectiveness of assessment procedures and spending and actual payments made to veterans'.[134] The committee agrees that the independent review by the Productivity Commission it has recommended should not be limited to the legislative framework and should also examine administrative responsibility and service delivery to veterans.

5.111 Some veterans expressed concern that future reform could result in some of the responsibilities of DVA being transferred to the Department of Human Services (DHS) or be delivered through Centrelink. The committee notes that the Minister on 7 August 2017 has confirmed that DVA will remain a stand-alone department and there are no plans to merge DVA with DHS.[135] The unique nature of military service

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132 NMHC report, p. 52.

133 Government response to NMHC report, p. 68.

134 *Submission 171*, p. 2.

135 The Hon Dan Tehan MP, Minister for Veterans' Affairs, 'No Change', *Media release*, 7 August 2017, p. 1.

means that there will always be a need for a specific agency responsible for the welfare of veterans, however the committee considers that the administrative role of DVA should be critically examined.

5.112 In the committee's previous inquiry into mental health of ADF and veterans, the committee stated it was not convinced that mandating statutory time limits for claim determinations would benefit veterans as it may have unintended consequences. However, statutory measures can operate shape administrative practices to deliver more timely outcomes for clients. Given the NMHC view on this topic, the committee considers this matter should be reassessed as part of independent review by the Productivity Commission. Delays in the processing of claims, and the uncertainty that resulted, were key stressors on veterans.

Recommendation 12

5.113 The committee recommends that the reference to the Productivity Commission should also include examination of the following areas in the Veterans' Affairs portfolio:

- **governance arrangements;**
- **administrative processes; and**
- **service delivery.**

5.114 The committee notes that the ANAO has indicated a potential audit of DVA's delivery of services to its clients for 2017-18.[136] The ANAO's work consistently provides valuable insights into effective public administration. While the ANAO review will not cover the breadth of issues which submitters have raised, an ANAO performance audit of the 'Efficiency of veterans service delivery by the Department of Veterans' Affairs' will complement and reinforce the work of administrative review by the Productivity Commission recommended by the committee. Given the evidence received during the inquiry, the committee consider the ANAO should undertake this proposed performance audit as a matter of urgency.

Recommendation 13

5.115 The committee recommends that the Australian National Audit Office commence the proposed performance audit of the 'Efficiency of veterans' service delivery by the Department of Veterans' Affairs' as soon as possible.

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136 ANAO, 'Efficiency of veterans service delivery by the Department of Veterans' Affairs: Potential audit 2017-18', *Annual Audit Work Program 2017-18*, available at https://www.anao.gov.au/work/performance-audit/efficiency-veterans-service-delivery-department-veterans-affairs (accessed 11 August 2017).

Chapter 6
Transition issues

Introduction

6.1 The period of transition to civilian life was identified as a critical time for the provision of support to veterans. Key issues related to this topic will be discussed in this chapter. The 2017-18 Budget estimated there were 59,194 permanent ADF personnel.[1] Of these serving members approximately, 5,500 discharge and return to civilian life each year. While most of these members are transitioning voluntarily, some are separating for medical reasons (900-1,000 each year) or are recruits who do not complete initial training (around 600-700 each year). Others separate for a range of other reasons which can include redundancy, reaching compulsory age retirement, for disciplinary reasons and administratively.[2]

Transition

6.2 In 2009, a review by Professor Dunt into ADF mental health and support through transition recommended that 'the ADF and DVA should have joint responsibility for a comprehensive transition service that works closely with the ADF Transition Centres and extends to at least 12 months post-discharge'. This recommendation was accepted by the Australian Government. It noted that 'Defence and DVA are working collaboratively to deliver a seamless transition service that ensures all reasonable assistance and support is available and utilised by members and their families preparing to transition to civilian life'.[3]

6.3 In June 2016, Defence and DVA reviewed and renewed the Memorandum of Understanding (MOU), first signed in 2013, which defines the respective roles of the two departments in the provision of care and support at all stages of an ADF member's career. Under the MOU:

- Defence has the lead in caring for, and supporting, permanent members and members on [continuous full time (CTF)] service as well as members of the Reserve Forces where they are injured or fall ill as a result of rendering Defence service;
- Defence is responsible for assisting members to transition from permanent or CFT service;
- DVA has the lead in caring for, and supporting, widows/widowers and dependants and wounded, injured or ill former serving members;
- DVA is responsible for providing compensation and other support to eligible current and former members; and

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1 Defence, *Portfolio Budget Statements 2017-18*, p. 26.

2 Government response to the NMHC report, p. 31.

3 Government response to the mental health care in the ADF and transition to discharge review, p. 14.

- DVA is responsible for ensuring current and former members, and where relevant their families, are kept informed of the support and services available from DVA and the processes by which such support and services may be accessed.[4]

6.4 As part of its responsibilities, Defence outlined the 'comprehensive transition support service for all separating ADF members and their families'. Defence offers the ADF Transition Program which is intended to operate 'through a continuity of care framework to ensure members and their families can transition from military to civilian life in a professional, dignified and supportive manner'.[5] It outlined:

> Staff at ADF Transition Centres undertake one-on-one interviews with all members separating from the ADF…During these interviews members and their families are provided with practical information on the transition process; administrative requirements; referrals to other government support agencies and service providers on matters such as access to educational, financial, rehabilitation, compensation and other government services; and support for training and civilian employment. All separating members must attend an ADF Transition Centre to finalise their administrative requirements and to be provided with transition information, prior to their date of separation.[6]

6.5 Defence highlighted the importance of ADF Transition Seminars in providing a wide range of information and advice to departing members:

> ADF Transition Centres conduct 23 ADF Transition Seminars each year. These seminars are held nationally throughout the year to inform members and their families of a range of Defence, government and other support organisation resources and information they can access to successfully plan for their transition to civilian life. ADF members and their families regardless of their length of service are encouraged to attend a seminar every few years to improve their knowledge, awareness and training for future separation.
>
> The Joint Health Command's LifeSMART presentation which aims to increase members' individual psychological resilience and develop awareness of better ways of coping with the challenges of transition to civilian life is included as part of the ADF Transition Seminar. The seminar also contains a specialised briefing to medically separating members from the [CSC], and presentations by DVA's [VVCS] on the Stepping Out Program and other support services available, DVA on a range of support available, the range and nature of ex-Service organisation support available, financial guidance and advice and guidance on activities to undertake to commence a new career.[7]

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4 Memorandum of Understanding between the Department of Defence and the Department of Veterans' Affairs for the Cooperative Delivery of Care and Support, 30 June 2016.

5 *Submission 124*, p. 13.

6 *Submission 124*, p. 14.

7 *Submission 124*, p. 14.

6.6 Defence indicated that it was reforming its ADF Transition Support Service.

> The Transition Support Service reform will see the Transition Officers move to a model of coaching and mentoring with a focus on developing an individual post separation plan (particularly around employment). This new model is aimed at all ADF members who are transitioning and will be implemented nationally by August 2017. Transition Officers will be able to discuss with the transitioning member their family needs in order to assist the transition to be more holistically smooth, as well as focussing on the member's overall wellbeing.
>
> This new model will also see the Transition Officers contacting each member one month after separation to check on the success of the post separation plan and whether any new issues have arisen.[8]

6.7 Defence also noted that there was assistance available through the Career Transition Assistance Scheme which 'provides eligible members with assistance that will facilitate their transition to civilian employment'.[9]

Key recent reforms

6.8 A supplementary submission from Defence and DVA highlighted their awareness of transition as a critical issue. Defence and DVA indicated that the recent efforts were partly based on a shift in perspective:

> Transition from a Defence perspective is largely a process by which people leave the ADF with support to assist their future lives. From a DVA perspective it is often the point at which responsibility starts for care and support of those who need it.
>
> A more holistic view would see transition in terms of outcomes for the veteran, rather than successful completion of the transition process. We would increasingly target our efforts towards those most in need based on criteria such as continuity of healthcare, finding employment and social connectedness. Those criteria, while valid for all, are more critical for a smaller percentage of members, including those whose transition is significantly complicated by health considerations, including mental health difficulties and those who separate involuntarily. Also, successful transition should be considered to include success for the former member's family in the areas of spouse employment, children's education, housing and financial security.[10]

6.9 The first recommendation of the NMHC report was that the Minister should 'should further examine how ADF and DVA can best develop a unified system that breaks down the siloed approach experienced by current and former serving members and their families'. It stated:

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8 Government response to NMHC report, p. 38.

9 *Submission 124*, p. 14.

10 *Submission 156*, Supplementary submission, p. 1.

> The goal should be to deliver instead a service offering that meets the needs of individuals in a seamless and person-centred way. Included in the work of this expert panel should be models for commissioning health services across ADF and DVA so that continuity of care for individuals moving from ADF to DVA funded services is maximised; agreeing a process that provides for automatic notification to DVA when a current ADF member suffers a work-related injury (to remove any later requirement to substantiate a work-related injury claim); and implementing processes that ensure contact is made periodically with former members of the ADF and their families to inform them of relevant services and other related information. Any administrative and/or legislative barriers to a unified service offering should be addressed as a priority.[11]

6.10 The Government response to the NMHC report stated that 'Defence and DVA are currently working closely together on a number of initiatives to create continuity and seamless transition where possible'. In particular, it noted that a cross-agency Transition Taskforce (comprised of DVA, Defence and Commonwealth Superannuation Corporation representatives) was reviewing the transition process with the aim of a significant reform that meets the needs of transitioning members and families.[12]

6.11 The Transition Taskforce was intended to 'identify barriers to effective transition and suggests actions to address those barriers'. The Government response noted:

> A variety of activities are being undertaken including workshops and interviews with current and former serving ADF members, and representatives of other organisations external to government that provide services or support during transition. The Transition Taskforce is also being informed by the work of AIHW and their analysis of suicide among the serving and ex-serving ADF personnel, which provides a strong evidence base from which we can target our efforts to those most at risk.[13]

6.12 Defence also indicated that the Discharge (Separation) with Documentation policy was being implemented through 'mandating Individual Transition Plans and Separation Checklists for all separating members'. This was intended to ensure members transitioning had all needed documentation to commence their civilian lives.[14]

6.13 DVA stated that a key enabler of its Veteran Centric Reform program was an Early Engagement Model. Under this initiative, Defence will provide DVA with basic details, including contact information, for all new members of the ADF from 1 January 2016:

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11 NMHC report, p. 52.

12 Government response to NMHC report, p. 69.

13 Government response to NMHC report, pp 39-40.

14 *Submission 156*, Supplementary submission 1, p. 2.

> The information will allow DVA to establish a record for new personnel from the day they join the ADF, allowing DVA to provide information on services and support, and encourage early lodgement of claims for service related conditions.
>
> In addition, from 27 July 2016, Defence will also be able to provide DVA with details of all members separating from the ADF. Over time, this will mean that DVA will have most current and former members of the ADF recorded as clients. This is in contrast to the past when DVA only knew about current and former members when they made a claim (about 20% from recent conflicts) or, more recently, when Defence started passing transition information to DVA, in some cases allowing the member to opt out.[15]

6.14 The Government response to the NMHC noted that Defence will support the Early Engagement Model by notifying DVA at agreed events during a member's career including events such as enlistment, involvement in a serious incident, medical separation, or retirement. This information would allow DVA 'to expedite the claims process whenever a current or former member applies to DVA for assistance'.[16]

6.15 Mr Lewis, the Secretary of DVA, outlined DVA intentions to 'reshape their systems and processes to bring ADF members on as DVA clients, in some cases with a compensation payment in the event of permanent impairment, while they are still serving'. He noted that these were not matters that 'need to wait until someone leaves the ADF and is trying to enter the DVA system months or years later on'.[17]

6.16 Identification and tracking of veterans after transition is another area of recent reform. In 2013, the Joint Committee report on *Report into the Care of ADF Personnel Wounded and Injured on Operations* recommended that Defence and DVA 'expedite the development of a unique service/veteran health identification number'. This proposal was supported in principle in the Government response to the report. It stated:

> The departments of Defence and Veterans' Affairs recognise that the use of a common identification number has the potential to improve the transition of Australian Defence Force personnel by reducing complexity, aiding proof of identification processes, and expediting data exchange. The Department of Veterans' Affairs, in consultation with Defence, is undertaking a scoping exercise to identify possible solutions and to inform a cost/ benefit analysis.[18]

6.17 DVA noted that during the 2016 election 'the Government committed to require Commonwealth agencies to identify whether their clients are veterans and to

15 *Submission 156*, p. 17.

16 Government response to NMHC report, p. 39.

17 *Committee Hansard*, 6 February 2017, p. 50.

18 Government response to the Joint Committee on Foreign Affairs, Defence and Trade, *Report into the Care of ADF Personnel Wounded and Injured on Operations*, December 2013, p. 6.

make that information available to ex-service and other organisations that provide support for homeless veterans'. It outlined:

> The Minister for Veterans' Affairs has written to relevant Commonwealth Ministers (Health, Aged Care and Sport; Social Services; Human Services; Small Business; Education and Training; and Employment) to nominate officers to work with the Department of Veterans' Affairs (DVA) on the feasibility of developing a standardised military service history indicator to use in Commonwealth agency data collections. This work will commence shortly.[19]

6.18 DVA added that the addition of a visual indicator on Medicare cards to indicate a 'veteran' would be considered as part of this process. However, it noted that '[t]he implementation of such an initiative would involve the Department of Health and the Department of Human Services as the policy and operational owners of Medicare, and the Department of Defence for the purpose of identifying current and former serving members in accordance with privacy considerations'.[20]

6.19 The NMHC report highlighted the need for a 'strategy for further data development and information priorities within the ADF/veterans context…to improve tracking and visibility of the need for, uptake and effectiveness of services for current and former serving ADF members and their families, as well as the experience and outcomes of these services'. It advised the Australian Government to consider 'a health data identifier for use in health data sets to identify when an individual is a current or former member of the ADF'.[21]

6.20 The Government response noted:

> The Commonwealth Veteran Indicator Interdepartmental Committee (IDC) has been established to identify what data is collected by Commonwealth agencies, what additional data could be collected, how the data can be used to inform veteran-related policy and program development more generally across government, and understand the constraints of introducing a veteran identifier in identified data collections.[22]

6.21 In relation to e-health records, the Government response noted that a self-identifying 'Veteran and Australian Defence Force Status' indicator has been available in the My Health Record system since 30 November 2014 should veterans choose to participate. It also indicated that the Department of Health would scope opportunities to include a self-identifying 'Veteran and ADF Status' indicator in the Primary Mental Health Care Minimum Data Set (PMHC MDS). The PMHC MDS is used to 'provide the basis for [Primary Health Networks] and the Department of Health to monitor and report on the quantity and quality of service delivery, and to inform future

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19 DVA, response to questions on notice from hearing 6 February 2017.

20 DVA, response to questions on notice from hearing 6 February 2017.

21 NMHC report, p. 55.

22 Government response to NMHC report, p. 71.

improvements in the planning and funding of primary mental health care services funded by the Australian Government'.[23]

Issues raised

6.22 A range of transition issues were raised by veterans and others. These included:

- gaps in support in the transition process;
- continuity of care issues, including non-liability health care;
- supporting social connectedness;
- employment and rehabilitation issues; and
- family and community support.

6.23 The NMHC report highlighted a wide range of reasons that the experience of transition from the ADF could negatively impact veterans. These factors were also reflected in the submissions received by the inquiry. These included:

- the psychological transition for ADF members from being a 'warrior' to becoming a civilian;
- involuntary discharge (for medical reasons, for instance) can have adverse implications for the wellbeing of service members;
- skills and training acquired during service are not relevant or valued in the civilian workforce; and
- a loss of social connections with friends and colleagues still serving in the ADF can reinforce the sense of isolation and loss associated with transition.[24]

Gaps in support

6.24 Some veterans suggested that structural policies against 'double-dipping' Defence-funded and DVA-funded support could result in some veterans being left without support while their entitlements were processed. One veteran stated:

> When the last ADF pay slip is satisfied, veterans must rely upon the '28 day – 120 day' timeframe to process Needs Assessments, Permanent Impairment, Incapacity Payments and Other rehabilitation services. With mortgage/rent payments to be made, school excursions to be paid for, and medical bills from rejected DVA claims (because Dr 'X' stated "sore ankle" rather than "insert relevant SOP wording here ") it is little wonder that the financial pressures on transitioning members exacerbate the spiral of depression towards suicide. The inability to progressively transition cases of accepted liability is further evidence of this 'gap': Serving members are

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23 Government response to NMHC report, p. 65.

24 NMHC report, pp 21-22.

> not entitled to medical treatment, rehabilitation or civilian incapacity payments.[25]

6.25 The RSL (Tasmania) submission referred to 'an ongoing perception within the ADF, particularly within the chain of command, that ComSuper and DVA will "pick things up" immediately upon a member's discharge'. It observed that, in reality, 'it can take many weeks or even months before income starts flowing from either source, leaving the member with no income for what can be an extended period if their discharge is not managed appropriately':[26]

> The delays involved in accessing entitlements due to the length of time involved in the claims process, which can be in excess of 12 months in some cases, contributes to the financial uncertainty and stress, and significantly detracts from the veteran's wellbeing and sense of self-worth. There have been several reports to advocates of veterans who, frustrated by their financial and health situation and by the delays and difficulties of the claims process, have expressed the feeling that their families "would be better off without them". This is extremely concerning, and demonstrates the significant impact that is being felt by veterans of the current state of the claims process. Many feel the process is complicated, confusing, unnecessarily bureaucratic, frustrating and uncaring. These feelings understandably feed the negative cycle of thoughts and feelings which are usually only resolved when a claim is finally determined favourably and money begins flowing again and their financial and support concerns are relieved.[27]

6.26 Mr Lee Withers described it as 'common practice' for the ADF to medically discharge people who had not had their DVA claims finalised. She noted that this could lead to 'newly discharged vulnerable members and their partners and children being forced into poverty, sometimes losing their house, car, the partner may have to give up work to care for the member therefore more loss of income, all the while dealing with the DVA/Comsuper red tape ring around'.[28]

6.27 The potential for these scenarios led many to recommend that veteran claims and entitlements should be resolved prior to discharge.[29] For example, Colonel Rob Manton (rtd) from Veterans SA commented:

> [E]very effort must be made to ensure that anyone and everyone transitioning from Defence at the completion of their service, regardless of their service history, should have their claims finalised by the Department of Veterans' Affairs prior to their discharge—that is, as far as possible, they remain an employee of the Department of Defence until the outcome of any of their claims is finalised. To speak plainly, they were broken while in the

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25 Name withheld, *Submission 258*, p. 4.

26 *Submission 169*, p. 21.

27 *Submission 169*, p. 30.

28 *Submission 22*, p. 3;

29 For example, Dr Nick Ford, *Committee Hansard*, 17 November 2016, p. 2.

> department. That department has a duty of care to ensure that they repair, or are well on the path to recovery, to the best standard possible.[30]

6.28 Similarly, the Northern Suburbs Veterans Support Centre urged that no member of the ADF be transitioned out 'until all claims for injuries have been dealt with and all avenues of appeals are exhausted'.[31] The Australian Suicide Prevention Foundation also pointed out that a 'prolonged transitional stage between active service and civilian life may assist with the alienation that many personnel will feel on leaving their colleagues'.[32]

6.29 Others considered there was still work to be done in ensuring veterans and their families have the right information and advice during the transition process. For example the Victorian Veterans Council Sector Study in 2015 provided by the Victorian Government highlighted commentary from ESOs and both older and younger veterans attending the consultations which 'contended that the current transition process is ineffective and leads to veterans who are not aware of what support is available to them and how to access it'. It made the point that if not appropriately transitioned, veterans are likely to experience difficulties from the beginning in becoming aware of and accessing services throughout the remainder of their lives.[33]

6.30 Similarly, Ms Julia Langrehr from RSL SA commented:

> ADF and veteran community are poor help seekers, and they may sit in these transition seminars feeling that they do not need any help and will be okay. Often there needs to be follow-up down the track, when people realise that they are having a few problems but do not necessarily remember what was told to them at that seminar…Ongoing support for families of veterans separating would help as well, particularly educating spouses and greater involvement in the transition so the spouses understand what support is available for their veteran and who to call.[34]

6.31 In the context of many service related physical and mental conditions which have a delayed onset, the fact that many veterans do not maintain a relationship with Defence and DVA after transition into civilian life was highlighted as a gap in support to veterans. Mr Robert Dick from the RSL told the committee:

> In a lot of cases we see veterans who have been out of the military for some years and they are handling their issues, whether it is PTSD, depression or anxiety, very well and sometimes can hide that from people when they are going through their transition. That may be significant for a few years and

30 *Committee Hansard*, 17 November 2016, p. 54.

31 *Submission 279*, p. 5.

32 *Submission 286*, p. 1.

33 *Victorian Veterans Sector Study Report 2015*, p. 32.

34 *Committee Hansard*, 17 November 2016, p. 47.

> then something in their life, a trauma or something, triggers that PTSD or anxiety and that is when it comes to the fore.[35]

6.32 Similarly, the joint submission from Dr Catriona Bruce and others highlighted estimates that only one in five former ADF members have client numbers with the DVA. It noted that the typical presentation of mental ill-health can be as much as 8-10 years, or longer, after discharge and that these 'lost veterans' are not provided with adequate entitlements or support and would therefore be at a higher risk of suicide. The joint submission proposed ADF-DVA transitioning staff have 'personal responsibility for every individual transitioning out of the ADF, regardless of circumstance, for a minimum follow-up period of 10 years'.[36]

6.33 In relation to this loss of connection with support, DVA highlighted the component of DVA's Coordinated Client Support program called the DVA Reconnects Project. This program aimed to reconnect with clients through proactive contact and the provision of a complex and multiple needs assessment.

> [T]he national DVA Reconnects Project seeks to contact those veterans aged 50 years and under who have rendered operational service in either the Iraq or Afghanistan theatres of operation, or who have one or more of the following accepted conditions:
>
> - Post-traumatic stress disorder
> - Major depression/Dysthymic disorder
> - Substance abuse
> - Acquired and/or traumatic brain injury
>
> Completed over a series of phases, the DVA Reconnects project is producing positive results early with feedback received from clients resoundingly positive of their contact experience. In some instances, DVA Reconnects has facilitated the reconnection with clients who have not had contact with the Department for 6-8 years. This allows DVA to provide appropriate, up to date benefits and supports to these individuals.[37]

6.34 Mr Craig Orme from DVA provided more further detail on this program:

> As part of that program, we have identified a reconnect program, which has been very successful, where we go into specified cohorts of groups. Maybe they are people who have not been in contact with the department for five or 10 years. They are between 30 and 40, and they have served in Afghanistan or Iraq. We are reaching out to them to engage with them because we know they have been clients, and we are trying to reconnect with them and say: 'How are you travelling? Are there any issues?' Some

35 *Committee Hansard*, 6 February 2017, p. 4.

36 Dr Catriona Bruce and others, *Submission 171*, p. 3.

37 *Submission 156*, p. 15.

> have not been appreciative of that, but the vast majority have. In many cases we have reconnected and in some cases recommenced treatment.[38]

Continuity of care

6.35 The Government response to the NMHC report outlined that 'Defence has the responsibility to provide health care up to the date of transition':

> Post transition this responsibility shifts to civilian health care services and if relevant, health services paid for by DVA….In the six months prior to transition all ADF members attend a number of health examinations that aim to help the member to identify any potential current or future health care needs that can be communicated to civilian general practitioners to improve early interventions and assist continuity of care post transition. These examinations can help members being medically separated to provide the appropriate medical evidence to the CSC to assist to determine the member's level of capacity and corresponding benefits.[39]

6.36 It acknowledged that '[f]or ADF members who are seeking rehabilitation, compensation or health care through DVA at the time of transition there can be some complexity involved in obtaining medical evidence to support the claim'. To streamline this process Defence indicated that a complete copy of their health record can be provided to the transitioning member or the Defence / DVA Single Access Mechanism (SAM) 'act on behalf of the member and seek the required service or health records to support the claim'.[40]

6.37 The SAM was established in 2010 to provide a single point of access for the transfer of records and information between Defence and DVA in order to enable DVA to determine a member's compensation claims. Records and information requested by DVA can include: service and medical records, personnel records, career management information and incident and investigation reports. Defence noted improving the performance of the SAM to reduce the time to process claims had been a focus of DVA and Defence 'for some time'. Improvements have been limited by a range of Defence records, particularly health records, being paper based.[41]

6.38 Defence indicated it was 'with [DVA] to decrease the time taken to assess claims, including a major initiative to digitise ADF member health records and provide access to DVA access through the roll out of the Defence eHealth System. Defence stated this would 'reduce reliance on paper based records and reduce time in assessing claims'.[42]

The DVA client satisfaction survey indicated a majority of veterans who had transitioned in the last five years expected DVA to hold information about them

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38 *Committee Hansard*, 6 February 2017, p. 60.

39 Government response to NMHC report, p. 32.

40 Government response to NMHC report, pp 32-33.

41 *Submission 124*, p. 15.

42 *Submission 124*, p. 4.

including their health information, information about injuries and service history.[43] In this context, some suggested there should be automatic transfer of responsibility from ADF to DVA for all veterans, including the transfer of complete ADF medical records.[44]

6.39 The NMHC report noted that transition from the ADF often means relocation and this can impact continuity of care of those discharging for medical reasons.[45] The challenges of continuity of healthcare to veterans transitioning to civilian life were highlighted by DVA to the committee. In particular, while Defence has Garrison Health Services on their bases in a defined number of places across the country, veterans live throughout Australia.[46]

6.40 The 2016 ANAO report into the MRCA found that 'Defence and [DVA] cannot yet demonstrate through comprehensive and reliable performance information whether the support provided is effective and efficient in assisting transition to civilian life or which services provide the best results for injured and ill ADF personnel discharged for medical reasons'.[47] In response to the ANAO report findings and recommendations, DVA indicated that it will 'work jointly with Defence to improve the effectiveness and efficiency of transition services for separating members of the [ADF]'.[48]

6.41 However, continuity of care for veterans was identified as an area where improvements could be achieved. For example, Phoenix Australia recommended reducing the 'fragmentation between the ADF and DVA service systems and enhance continuity of care':

> There is a lack of continuity in clinical care – members often have to terminate with one mental health provider and commence with another at the point .of discharge. This not only disrupts treatment but, more importantly, creates a high risk of the person falling through the cracks and out of the care system. It is important to develop strategies to develop and maintain clinical continuity.
>
> We recommend DVA and Defence develop one integrated service system, or if this is not possible, at least extend the period that Defence health services are available post-discharge from 1 to 2 years.[49]

6.42 A joint submission from Dr Catriona Bruce and others recommended:

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43 DVA, *2016 Client Satisfaction Survey*, May 2017, p. 19.

44 *Submission 171*, p. 3.

45 NMHC report, pp 21-22.

46 Ms Campion, DVA, *Committee Hansard*, 6 February 2017, p. 59.

47 ANAO, *Administration of Rehabilitation Services under the Military Rehabilitation and Compensation Act 2004*, May 2016, p. 10.

48 DVA, *Annual report 2015-16*, p. 30.

49 *Submission 177*, p. 4.

> Provide interim full-cover health insurance and income support measures, effective immediately from ADF discharge until the DVA has completed the decision making process, to ensure that all transitioning medically-discharged veterans, or those awaiting DVA assessment outcomes, are not disadvantaged during this period. If the DVA administrative process is efficient and timely, the burden of cost for these transitional payments will not be onerous. This funding should be in the form of income support payment and must cover all medical care in line with the gold card benefits, to enable veterans to treat injury and prevent further physical and mental health deterioration during this indeterminate time.[50]

6.43 The RSL also questioned whether the award of monetary compensation was the best outcome for veterans rather than 'something else…such as comprehensive lifetime health care (i.e. the issue of a gold card). It commented:

> A focus on rehabilitation rather than compensation also raises the expectation that individuals may, or should, be fully rehabilitated and integrated within civilian life and employment within a reasonable period. This opens the possibility to the issue of 'time-limited gold cards'. Under such an approach, it might be feasible for individuals transitioning out of the ADF to be issued a, say, ten-year gold card in the understanding that any outstanding health conditions could be treated and remedied over that period. Compensation and pensions would only be available for conditions that have no prospect of remediation, either at the time of transitioning out of the ADF, or at the expiry of the gold card.[51]

Further extending non-liability health care and automatic entitlements

6.44 There was almost universal praise from stakeholders regarding the extension of non-liability health care for all mental health conditions. One submitter recommended that all 'departing members of the ADF be issued a Non Liability Health Card for Mental Health prior to discharge'.[52] A number of submitters and witnesses supported increased automatic healthcare entitlements on discharge. For example, Dr Jonathan Lane proposed that non-liability health care be extended to all service veterans, for all health conditions:

> This may have an initial higher cost, but as seen with the limited access to specific mental health conditions now, it would improve access to treatment, and therefore reduce the overall level of treatment required, as well as the duration of that treatment. This should reduce the administrative cost and workflow burden to DVA in terms of the liability determinations which are the majority of the basis for complaints, as well as the ongoing administrative and treatment costs by ensuring that veterans get adequate and early treatment for problems.[53]

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50 *Submission 171*, p. 2.

51 *Submission 216*, p. 12.

52 Name withheld, *Submission 222*, p.

53 Dr Jonathan Lane, *Submission 78*, p. 4.

6.45 Mr Max Ball urged the committee to consider proposals to 'that all veterans who have given operational service be issued, at the time of their retirement or discharge, with a DVA Gold card for treatment only of all future conditions, and that a member of the ADF, without operational service be issued with a Gold Card for the continued treatment of illnesses or injuries for which they have been treated during their service in the ADF'.[54]

6.46 Professor Philip Morris considered that '[g]iving all ex-ADF personnel a Gold Card treatment entitlement equivalent' facilitate post-discharge support and allow more detailed monitoring of health status and service usage.[55]

6.47 Mr Arthur Ventham believed that 'the Non-Liability Health Care (NLHC) range of health conditions should be expanded to include all those conditions that are included in the list of "Top 20 accepted conditions"'. He considered this would 'go a long way' to alleviating the stress associated with the DVA claim process. Further, he recommended granting an automatic Gold Card for every veteran with operational service or who is medically discharged from the military should be investigated:

> The real cost of the scheme is between $3000 and $4000 per veteran per year...Costs do not consider the savings which would occur because of veterans' early access to ongoing medical treatment, the ability of veterans to stay in the workforce because of this early access and the reduced legal costs to the DVA.[56]

Social connectedness

6.48 When ADF members transition they go from a regulated and highly structured culture with many colleagues to a civilian life which may be very different. Ensuring that veterans continued to be socially connected as often perceived as vital to their well-being. For example, Dr Jonathan Lane noted that 'the process of discharge and separation from Defence means that people lose these social connections (and therefore support) simply because they have left Defence'.[57] He commented:

> A key part of the diagnostic criteria for depression, for example, is social withdrawal and social isolation. A key part of the diagnostic criteria for PTSD is social withdrawal and social isolation. When people withdraw socially and isolate themselves, it exacerbates the depression and it exacerbates the physical problems and their mental problems...One way of changing that is by having more support for the veterans organisations and the veterans groups and looking at treatment methods that are outside the mainstream providers of treatment such as the psychiatrists or psychologists.[58]

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54 *Submission 323*, p. 3.

55 *Submission 384*, p. 4.

56 *Submission 295*, p. 12.

57 Dr Jonathan Lane, *Submission 78*, p. 5.

58 *Committee Hansard*, 17 November 2016, p. 20.

6.49 Dr Lane observed that groups like 'Groups like Mates4Mates and Soldier On have demonstrated their capacity for increasing social connection, providing access to alternative forms of therapy, social and functional support'. He recommended that these ESOs 'should be funded to develop and implement simple, low level, generalised mental health programs conducted by people similar to themselves (i.e. peers,) which should improve social connection, emotional regulation, communication, and resilience, and hence improve general functioning'.[59]

6.50 Similarly, Soldier On reported it had 'heard from many participants that the greatest stress they experience in their military career is the process of transition':

> In the ADF, members are constantly surrounded by like-minded individuals, rules and systems they understand and a purpose greater than themselves. When they transition from the ADF to the civilian life, they often lose their friends, their job and their understanding of how life operates. Their sense of identity, tribal connection and purpose disappears in that one moment. This can easily lead to alienation and isolation from family and civilian society which can predispose the veteran to more acutely experience trauma than if surrounded by strong social networks.[60]

6.51 The important role that ESOs can play in promoting social connectedness and providing peer support for veterans was frequently highlighted. The NMHC considered a 'greater role for peer workers and ESOs to support transition would be desirable'.[61] The William Kibby VC Veterans' Shed also emphasised the potential of small volunteer ESOs to undertaken flexible rehabilitation and social support activities for veterans:[62]

6.52 Phoenix Australia also proposed a more assertive outreach role by ADF units and ESOs to improve 'ongoing formal and informal surveillance of health status and facilitation of connectedness' for veterans. It stated:

> For many members…their closest association is with their unit. We recommend funding an increased role for the member's unit in maintaining contact after discharge. This may take the form of stronger 'alumni' networks, as well as continuing initiatives such as Operation Life and KYMS (Keep Your Mates Safe) during the period of adjustment to civilian life…
>
> There is also the potential for the ex-service organisations to play an important role in informal monitoring and outreach to veterans across the community, and in facilitating connectedness for veterans at risk of social alienation and suicidality.[63]

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59 *Submission 78*, p. 7.

60 *Submission 175*, p. 4.

61 NMHC report, p. 53.

62 For example, Mr Barry Heffernan, *Committee Hansard*, 17 November 2016, pp 31-32.

63 *Submission 177*, pp 4-5.

6.53 One example of support for younger veterans was highlighted in the Government response to the NMHC report:

> The Supporting Younger Veterans (SYV) grants program supports the needs of younger veterans as they leave the ADF and integrate back into civilian life, with all the challenges that accompany that unique transition.
>
> The SYV grants program provides $4.25 million over five years to ESOs to encourage partnerships that will deliver innovative and sustainable services for younger veterans and build community capacity to meet the needs of younger veterans. These programs such as mentoring, team building or self-improvement activities, will contribute to the Government's strategies to support those veterans at a higher risk of suicide (18-29 year olds).[64]

6.54 The committee's 2016 report into mental health recommended that Defence 'work with ex-service organisations to develop a transition mentoring program, which [would] connect every veteran with a trained mentor from the ex-service community to assist and guide them through the transition process'. In its response the Australian Government noted that 'engaging with groups like ex-service organisations can be important during the transitioning process' but did not accept the recommendation.[65]

Employment and rehabilitation

6.55 The capacity of veterans to gain fulfilling employment following their service was seen as a critical factor in future success. AISRP noted that 'work provides social contact, goals, purpose, meaning, financial security, exposure, and positive interactions, all protective'.[66] However, Mates4Mates noted that for 'many ex-service members, one of the biggest challenges associated with the transition process is accessing, and adjusting to, the civilian workforce'. It stated:

> Navigating the civilian training, education or job search process can prove particularly overwhelming. Becoming familiar with civilian workplace practices can be even more challenging, particularly when the ADF 'rules' fail to apply in civilian workplaces – this can lead to immense confusion, frustration and agitation for the ex-service member and can significantly impede their ability to assimilate into a new work environment and exacerbate their feelings of isolation and disconnection.
>
> We know the research that points to employment being a restorative psychological process. Positive and meaningful employment experiences are linked to improved self-esteem, self-efficacy and high levels of personal empowerment – all of which have a positive effect on mental health and wellbeing. However, many veterans often report having negative civilian workplace experiences, particularly soon after discharge. For many, this can often be linked to not being provided with appropriate career coaching or mentoring support early on following their transition from the military.

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64 Government response to NMHC report, p. 41.

65 Government response to Senate Foreign Affairs, Defence and Trade Committee report, *Mental Health of Australian Defence Force Members and Veterans*, September 2016, p. 15.

66 *Submission 174*, p. 3.

> There is no substitute for what employment offers in the way of structure, support and meaning. But it needs to be the right job, based on the veteran's skills, experience and aspirations. In the same way that it's vital that clinicians who treat veterans understand the 'rules' veterans are used to living by or the 'lenses' through which they view the world, career transition providers working with veterans also need to have the very same contextual understanding in order to work successfully with veterans.[67]

6.56 Dr Andrew Khoo also noted that '[l]eaving a job frequently involves a loss of an individual sense of purpose/meaning, however for many exiting the military also involves a loss of identity, culture and honourable purpose'. He stated:

> My anecdotal feeling is that this particular risk factor contributes disproportionately in veteran suicidal behaviour. Results of a piece of research carried out at Toowong Private Hospital into military related suicide show that employment of any type is protective verses suicide and that unemployment or TPI/long term pension arrangements are predictive of suicidal behaviour.[68]

6.57 While veterans gain many transferable skills during their service, they also live within an institution which regulates their lives to a greater extent than a civilian employer. Consequently some advocates and their families considered veterans were sometimes deskilled in parts of civilian life. These included skills such as applying for employment, negotiating salaries and workplace conditions and interacting with public sector services. One veteran's wife commented:

> My husband did 23 years in the Australian Army. He left and didn't know how to write a resume. He didn't know he needed health insurance. He didn't know what a Medicare card was.[69]

6.58 Others highlighted barriers and misconceptions which may deter employers from hiring veterans. For example, Dr Nick Ford noted that '[e]mployers can fret about hiring someone with a treated psychiatric condition and worry about workers compensation issues and may be reluctant to hire'. He suggested '[e]mployment opportunities could be enhanced and this could be addressed by, for example, DVA underwriting compensation issues if they occur'.[70]

6.59 Mr Adam Usher highlighted some of the problems for veterans in finding employment when they have service-related injuries. He stated:

> One of the biggest issues facing veterans under the VEA is that you can be deemed unable to work because of service injuries, but DVA can find that you 'could' work more than 8 hours a week. You can end up in a state of limbo where you can't get workers comp insurance and are not allowed to work, but DVA says you 'could' do more than 8 hours, so no money piss

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67 *Submission 173*, p. 5.

68 *Submission 155*, p. 5.

69 Name withheld, *Submission 435*, p. 1.

70 *Committee Hansard*, 17 November 2016, p. 2.

> off. What do you do then? Serious question...I've been stuck here for 2 years...what do I do now? Gold card and $14K a year don't count for much. I'd much rather be working. I used to make $100K/year. So how exactly do I do that when I can't pass a pre employment medical and get insurance anymore due to service injuries.[71]

6.60 Dr Kerr from AISRP noted that in her clinical experience she had not found rehabilitation providers 'particularly effective' and that more could be done in relation to the arrangements for transfer to civilian employment. She noted that veterans were reporting to her that they felt they were 'not being given meaningful work'.[72] She stated:

> …I have known clients who want to go out and receive jobs, and there have been very significant places that have said, 'Yes, we will employ you,' but they cannot do it because they are tied to Defence. I do not understand why they cannot be doing work placement, paid work, and making that transition really smoothly.[73]

6.61 In May 2016, the Australian National Audit Office (ANAO) published the report of its audit of the administration of rehabilitation services by DVA and Defence under the MRCA. It noted that the MRCA was the most relevant rehabilitation and compensation legislation for current serving Australian Defence Force (ADF) members and cadets.

> In managing rehabilitation programs, neither Defence nor Veterans' Affairs reliably measure, monitor or report on outcomes. Civilian rehabilitation schemes, for example, use critical measures of performance; namely the timeliness of rehabilitation following injury or illness, and the durability of return to work outcomes. Accrued liabilities under the MRCA are significant and growing. Robust performance information has not been sufficiently developed or used by Defence and Veterans' Affairs to manage the MRCA scheme overall, from assessing the risks of injury and illness in Defence through to considering the impact of rehabilitation on the overall performance and financial sustainability of the scheme.
>
> The return to work rate, a third key indicator of the effectiveness of rehabilitation services, is significantly lower than the national benchmark—54 per cent for Veterans' Affairs and 55 per cent for the ADF, compared with the Australian average of 77 percent in 2013–14. The rate of medical separations from the ADF has increased from 12 to 19 per cent of people leaving the ADF between 2010 and 2015. There has been a significant decline in the rate of transition to civilian work for Veterans' Affairs rehabilitation clients from 66 per cent to 48 per cent over the same period.[74]

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71 *Submission 114*, p. 1.

72 *Committee Hansard*, 2 February 2017, p. 4.

73 *Committee Hansard*, 2 February 2017, p. 7.

74 ANAO, *Administration of Rehabilitation Services under the Military Rehabilitation and Compensation Act 2004*, May 2016, p. 10, pp 8-9.

6.62 The ANAO audit found that:

> …the return to work rate is significantly lower than the national benchmark—54 per cent for DVA and 55 per cent for the ADF, compared with the Australian average of 77 per cent in 2013–14. There has also been a significant decline in the rate of transition to civilian work for Veterans' Affairs rehabilitation clients from 66 per cent to 48 per cent over the same period.[75]

6.63 Phoenix Australia considered there was 'still scope to place a higher expectation on all those involved in the transition period to ensure that some kind of occupational role is in place for all members following discharge'. It recommended 'an expanded focus on proactive vocational engagement in partnership with non-Defence organisations, ex-service organisations, and industry to offer direction, structure, and facilitate the engagement of discharging veterans with new vocational options'.[76]

6.64 Soldier On highlighted some of the issues with previous transition processes:

> The current transition program offered through Defence in the form of the Career Transition Assistance Scheme (CTAS), in its current state, is limited in scope. Levels of support are currently dependent on time in service, or how one leaves the ADF. Transition Seminars are not yet mandatory and run for just two days. Support through CTAS is financial in nature and the onus is on the serving member to find a service provider to assist them with identify potential pathways post transition. All of this happens within a relatively short period. Access to these services also ends once members have separated from the ADF, particularly for those who do not enter the DVA system. As a result, many vulnerable members are separately from the ADF without the support they need to effectively transition to civilian life.[77]

6.65 Col Rob Manton (rtd) from Veterans SA noted work that the South Australian Government was undertaking to develop a veterans' employment framework educating both transitioning personnel and potential employers. In the case of the case of the veteran this would include how to apply for positions, how to address selection criteria; and, in the case of employers, having a clear understanding of the value-add an ex-serving member can bring. He stated:

> [W]e must do whatever we can to ensure transitioning Defence personnel have the opportunity to meaningfully compete for employment in the civilian community. It may surprise many employers to know that not every service person suffers from post-traumatic stress or is unable to undertake meaningful employment because of their operational experience. Most can and are eager to get on with the next phase of their lives.[78]

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75 *Submission 160*, p. 37

76 *Submission 177*, p. 6.

77 *Submission 175*, pp 8-9.

78 *Committee Hansard*, 17 November 2016, p. 55.

6.66 Partners of Veterans Association of Australia (PVAA) suggested the media attention on former ADF members suffering with mental health could perversely inhibit 'the chances of transitioning members to gain employment'. It recommended a media campaign 'to advertise the skills gained by the men and women whilst a member of the ADF and how those skills would benefit companies employing them'.[79]

6.67 DVA commented that '[r]ehabilitation is a key benefit provided in addition to treatment and is specifically designed for each individual to aid recovery and maximise their quality of life'. Three types of rehabilitation support are available to DVA clients:

- medical management rehabilitation services;
- psychosocial rehabilitation services; and
- vocational rehabilitation services.[80]

6.68 DVA emphasised that the 'funding for rehabilitation benefits and services is uncapped and demand driven, and provided independent of, but complementary to, other DVA benefits and services'. Under the VEA rehabilitation is voluntary, however rehabilitation is a key feature of the MRCA and the SRCA. It stated:

> The MRCA and SRCA assume that rehabilitation can, over time, result in positive changes in quality of life for all eligible veterans, regardless of the severity of their current physical or mental health status. As veterans are often unable to continue in or return to pre-injury employment, DVA seeks to assist them to maximise their quality of life and when appropriate, explore other work options through participation in a rehabilitation program.
>
> DVA provides rehabilitation services via a mix of in-house and outsourced arrangements. DVA has staff who are rehabilitation service coordinators who approve funding and rehabilitation plans. Actual delivery of rehabilitation services are outsourced via Comcare approved rehabilitation providers who develop rehabilitation plans, liaise with clients and their families, engage services, and monitor progress. These providers also meet specific DVA requirements to work with veterans.[81]

6.69 Issues were identified when serving members transition from ADF rehabilitation program to DVA services. DVA noted that it was working 'cooperatively' with Defence to 'ensure the rehabilitation needs of serving members and veterans, including the transition out of Defence, are met as legislatively required'.[82]

6.70 Defence noted a number of initiatives in relation to employment including the improvements to the CTAS for more members to have 'a resume developed and to be

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79 *Submission 45*, p. 3.

80 *Submission 156*, pp 26-27.

81 *Submission 156*, p. 26.

82 *Submission 156*, p. 27.

coached in job search techniques, application writing and interview skills'. It also noted the 'Transition for Employment Program aims to prepare medically separating ADF members, while they are still serving, to be competitive in the civilian job market through a suite of preparatory services and ongoing support, commensurate with their recognised medical condition'.[83]

6.71 On 17 November 2016, the Prime Minister and the Minister for Veterans' Affairs announced a number of initiatives in relation to employment by veterans including the formation of an Industry Advisory Committee on Veterans' Employment to consider how to mentor ADF personnel and translate ADF skills for the private sector. Other aspects of the announcement included:

> Businesses will be encouraged to partner with a local Ex-Service Organisation, such as the RSL and Soldier On, to develop strategies for driving veterans' employment through an Ex-Service Organisation Industry Partnership Register.
>
> The Government will help our ADF personnel by improving the transition from the Defence force into their post-service careers. All personnel will have appropriate documentation, including health records, superannuation and training records, and participate in the formal transition process before separating from the ADF. All separating ADF personnel will also have access to employment coaching services to help them seek and obtain employment.
>
> The Australian Public Service Commission (APSC) will participate in the transition process and develop a toolkit for veterans seeking employment in the public service. The APSC will also improve information for veterans seeking employment in the public service and launch an online tool for aligning ADF rank to APS classification. The new APSJobs website will include specific information for veterans seeking employment in the APS when it launches in 2017.[84]

6.72 In addition, Budget 2017-18 provided of $2.7 million over four years to support the further implementation of the Prime Minister's Veterans' Employment Program.[85] Budget papers indicated that:

> Defence continues to work with [DVA], industry and ex-Service organisations to support ADF members through the transition process and to find a new career. Key priorities include the Australian Defence Force transition transformation program, comprising job search preparation, a

83 *Submission 124*, p. 16. See also Rear Admiral Wolski, *Committee Hansard*, 6 February 2017, p. 20.

84 The Hon Malcolm Turnbull MP, Prime Minister and the Hon Dan Tehan MP, Minister for Veterans' Affairs, 'Supporting Veteran Employment Opportunities', *Media release*, 17 November 2016.

85 DVA, 'Supporting veterans’ employment opportunities', Budget 2017-18, p. 1.

> new transition coaching model, separation with documentation and enhanced post separation support.[86]

Family and carer support

6.73 DVA noted that at a recent Veterans' Families Forum '[a]ll participants…saw a need for planning for transition to start as early as possible in a member's career and to continue beyond separation from the ADF'. At the forum there was 'a consistent view that transition was a matter for the whole family, not just the member'.[87]

6.74 Rear Admiral Wolski, Head People Capability at Defence emphasised the role of the Defence Community Organisation (DCO) which offers a range of information, programs and services to assist Defence families:

> There are family support, community support mechanisms in place around Australia at the major bases, and there is the family helpline, which is available 24 hours a day to allow families to call in with any questions regarding how better to cope with military life.[88]

6.75 The DCO includes over 200 staff across Australia and includes social workers, military support officers, regional education liaison officers and family liaison officers.[89] He also outlined how families were included in the transition process:

> We recognise that the family is a part of the transition process, the family can also come along to their further transition seminars to hear all of the information that is being given to the ADF members in transition. That is basically helping to prepare the family strategies for being ready for being outside of the military and outside of all of those protective measures that we have put in place while the member is in uniform.
>
> There is a range of different points that are covered in our transition seminars, including things around medical advice—including getting Medicare, getting private health insurance—financial advice and all of those steps that assist the family and the member.[90]

6.76 Vice Admiral Griggs also noted that Defence Families of Australia was another organisation that is completely focused on military families and family support.[91] This is a government supported advocacy body with the goal to ensure quality of life for 'all Defence families by providing a recognised forum for their

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86 Defence, *Portfolio Budget Statement 2017-18*, p. 25.

87 *Submission 156*, Supplementary submission, p. 4.

88 *Committee Hansard*, 6 February 2017, p. 20.

89 Department of Defence, 'About DCO', available at http://www.defence.gov.au/DCO/About/Default.asp (accessed 19 July 2017).

90 *Committee Hansard*, 6 February 2017, p. 20.

91 *Committee Hansard*, 6 February 2017, p. 21.

views and by reporting, making recommendations and influencing policy that directly affects families'.[92]

6.77 This importance of support for the families during and after discharge was also expressed in submissions to the inquiry, which outlined a range of family support issues. For example, Soldier On noted that many military families felt that there was lack of training and access to appropriate services to assist them support veterans returning to civilian life.

> Current services available to veterans do not extend to their families. Transitioning from the ADF poses significant challenges for families as they adjust to civilian life which may include relocating, buying a house and forming a new routine. Families also require assistance to support veterans as they find work and seek help for any underlying physical or psychological injuries.[93]

6.78 In addition, Soldier On highlighted evidence concerning how the families of veterans could be affected. It noted:

> Research into the experience of Vietnam Veterans highlighted how the family unit was affected by the veteran's service. Compared to the general population, children of Vietnam Veterans are more likely to be diagnosed with or treated for depression (21 percent vs 14 per cent), anxiety (22 percent vs 13 percent) or PTSD (4 percent vs 1 percent). It was also identified that children of Vietnam Veterans have a suicide rate three times higher than the national average.
>
> Empirical studies have demonstrated that partners of combat veterans have a significantly higher risk of developing psychological problems as a result of living and caring for their veterans than the general population.[94]

6.79 The submissions from partners of veterans who, often at a young age, had taken on the responsibility of being part-time or full-time carers also illustrated the impacts on families after service. For example, Mrs Bonny Perry stated:

> I feel that one of the gaping holes in the system is lack of support for the family. We are given these broken people, people we barely recognise, and are not given any tools to help. We are the ones that have to support these wounded 24/7. With that, it means that, without the right tools the wheels are going to fall off.[95]

6.80 Similarly, Dr Nick Ford commented:

> Lack of sufficient transition support and relationship / family support means that families are not of equipped to deal with symptoms of PTS etc and the breakdown of these relationships for a fragile veteran can be catastrophic

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92 Defence Families of Australia, 'About', available at http://www.dfa.org.au/about (accessed 17 July 2017).

93 *Submission 175*, p. 9.

94 *Submission 175*, p. 6.

95 *Submission 193*, p. 1.

> and lead them to feeling and being alone with exacerbated feelings of pain and helplessness. Family involvement, early, is good psychiatric practice.[96]

6.81 Mates4mates emphasised the importance of providing family members with the education and tools to support veterans. It stated:

> There is a lot of useful information and material online from various agencies but providing opportunities for veteran's partners and family members to access accredited training such as Mental Health First Aid training and Applied Suicide Intervention Skills Training is important. Often family members can feel helpless and inadequate when faced with a loved one experiencing emotional or psychological pain. However, being provided with training in areas such as recognizing the signs of mental health problems or suicidal ideation and skills in how to respond in crisis situations can provide family members with increased confidence. This type of training could be funded through DVA but coordinated by ESO's who have the flexibility and capacity to provide the family members with additional wrap around support services.[97]

6.82 Professor Philip Morris stated:

> An important way of empowering ex-ADF personnel and their families to deal with mental illness and suicide risk is to provide them with training in mental health first aid. This will have the additional benefit of further de-stigmatising mental illness. At the point of discharge from the ADF the leaving member and his/her immediate adult family should be provided the 'Mental Health First Aid Course' suitably modified to take into account common conditions suffered by ex-ADF personnel as well as how to respond to potential and real suicide risk situations. In a similar way an occupational health intervention of mental health first aid training should be introduced for all individuals in leadership positions in the ADF.[98]

6.83 Several people with experience in working with veterans highlighted the tension between respecting the privacy of the veteran and assisting them through involving their family. For example, Mr Robert Dick from the RSL stated:

> As an ex-pensions and welfare officer, I have had situations where a veteran has come to me with an issue and I have taken that on board and helped him through the process. I have said, 'I'd like to be able to talk to your wife on certain issues, totally in confidence,' and he has said, 'Oh, no, she doesn't even know I'm here'.[99]

6.84 The PVAA also highlighted the need for respite assistance. It noted that '[w]hen life becomes too stressful on the family it is likely one of the partners will opt to move out'. The PVAA drew attention to a 'scarely used' VVCS Crisis Assistance Program which aims to provide short-term accommodation for up to five days to

96 *Submission 44*, pp 1-2.

97 *Submission 173*, p. 4.

98 *Submission 384*, p. 4.

99 *Committee Hansard*, 6 February 2017, p. 6.

Vietnam veterans.[100] It proposed this service could be widened to cover respite for any other veteran and/or their partner and family.[101]

6.85 Carers NSW stated that carers, including carers of veterans, were 'often recognised for their role or included by health professionals'. It outlined Australian and international evidence which suggested that 'carer inclusive veteran support has positive outcomes for veterans and their carers, reducing rates of depression and anxiety among carers and increasing the sustainability of their caring role'.[102]

6.86 It noted that the carers of veterans have reported their desire for greater education about particular mental health conditions and improved communication with mental health professionals. Carers NSW recommended that 'the carers of veterans living with a mental health condition and at risk of suicide be provided with a range of tailored support types, delivered both individually, such as specialised counselling, and in group contexts, such as training sessions and opportunities to mix with other carers in similar situations'.[103]

6.87 The Australian Families of the Military Research Foundation identified a lack of child care as a barrier to accessing mental health and other services:

> [I]t is vital to encourage the partners of younger servicemen/women as well as the servicemen/women themselves to seek help at [VVCS] as soon as family dysfunction threatens. But for mums with young children, finding child care for the period of the recommended face-to-face counselling may be difficult…
>
> [T]he VVCS is prevented by the Repatriation Commission from arranging child care. It may not, for instance, bring in a casual child minder or nanny for a day or half a day. Even if face-to-face counselling is considered most clinically appropriate in a particular case, but lack of child care prohibits it, only the second best and possibly unsatisfactory option of telephone counselling will be offered. This is surely not good enough.[104]

6.88 The 2013 Joint Standing Committee on Foreign Affairs, Defence and Trade inquiry into the Care of ADF Personnel Wounded and Injured on Operations recommended that Defence and DVA undertake a study into psychological support of partners and families of Australian Defence Force (ADF) members and ex-ADF members.[105] This was supported in principle in the Government response.[106] A family

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100 Veterans and Veterans Families Counselling Service, 'Crisis Assistance Program', available from http://www.vvcs.gov.au/Services/crisis-assistance-program.htm (accessed 24 May 2017).

101 *Submission 45*, p. 3.

102 *Submission 280*, p. 1.

103 *Submission 280*, p. 3.

104 *Submission 164*, pp 4-5.

105 Joint Standing Committee on Foreign Affairs, Defence and Trade, Inquiry of the Defence sub-Committee, *Care of ADF Personnel Wounded and Injured on Operations*, June 2013, pp xx-xxi.

well-being study is a component of the Transition and Wellbeing Research Programme.

6.89 The NMHC report recommended:

> The ADF and DVA should rethink the strategy and range of initiatives to support families. A Family Engagement and Support Strategy should be co-designed with families, and focus on known stress points for families, including transition points. The strategy should also recognise and cater for the diversity of family structures in the ADF and in ex-serving communities.[107]

6.90 The Government response to the NMHC report agreed that more support was needed for the family of current and former ADF members. It acknowledged that families 'make a significant contribution to the health and wellbeing of ADF members throughout their careers, through the transition process and when they become civilians' and that the 'role of family can be particularly important in the treatment and recovery of ill or injured individuals throughout their lifetime'.[108] It stated:

> A number of initiatives are currently being implemented in support of families.
>
> Defence has a family engagement model currently under development that includes engagement with VVCS.
>
> As part of its election commitments, the Government has initiated the Female Veterans and Families Forum.
>
> Support has also been provided for services for children of veterans with mental health conditions through the Kookaburra Kids Foundation.[109]

6.91 The NMHC also supported greater inclusion of families by the ADF:

> The ADF should review its current approach to implementing family sensitive practices, and implement any necessary changes in policy, practice and training to ensure that services are truly inclusive and family sensitive, particularly in relation to engaging with families when there is a report or incident of self-harm or suicidal behaviour. Any approach that denies involvement of families on superficial privacy and/or security grounds should be vigorously challenged, with a robust process implemented to regularly assess the experience of families in being engaged and participating in health services.[110]

6.92 The Government response included:

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106 Government response to Joint Standing Committee on Foreign Affairs, Defence and Trade, *Care of ADF Personnel Wounded and Injured on Operations*, December 2013, p. 5.

107 NMHC report, p. 52.

108 Government response to NMHC report, p. 8.

109 Government response to NMHC report, p. 69.

110 NMHC report, p. 53.

> Defence will continue to develop its family sensitive approach. Defence, (through Joint Health Command and DCO) will implement a family engagement model in the treatment of ill and injured ADF members supported by improvement in family sensitive practice amongst Defence health providers. To ensure a family-inclusive approach, co-design will be a priority in the development of these new support programs and initiatives. Work is also being undertaken to improve the support programs available to families to increase awareness levels and to provide advice on how to access these programs.[111]

Conclusion

Transition issues

6.93 Appropriate transition support for veterans can be critical to success in life after service. The committee supports the NMHC recommendation that 'transition should enable 'all departing personnel to leave with dignity, hope and some certainty about their future, regardless of the circumstances of their discharge'.[112] In this context, the committee welcomes the significant reform work which Defence, DVA and CSC are undertaking to improve the transition process for veterans through the Transition Taskforce.

6.94 In the view of the committee, the Transition Taskforce is an appropriate avenue to address concerns regarding the experience of transition which were raised by submitters to the inquiry. Worrying gaps in support were identified in submissions for veterans after discharge. Some veterans highlighted significant barriers to finding employment which were service related. These included lack of recognition of skills and training gaining while in uniform and a reluctance of employers and their insurers to employ veterans with service related conditions.

Recommendation 14

6.95 The committee recommends that Transition Taskforce examine and address:

- **any gaps in medical services or income support for veterans in transition or immediately following transition;**
- **barriers to employment for veterans who are transitioning such as workers' insurance issues and civilian recognition of qualifications, skills and training; and**
- **disincentives for veterans to undertake work or study resulting from the legislative or policy frameworks of the Department of Veterans' Affairs.**

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111 Government response to NMHC report, p. 69.

112 NMHC report, p. 53.

A two-track transition process

6.96 The period when ADF members transition to civilian life is even more important for the delivery of support and assistance to vulnerable veterans. As the research base grows in relation to the welfare of veterans (including risk of suicide), this research should be utilised to construct targeted support programs directed to the most 'at risk' groups as they transition from the ADF.

6.97 This two-track transition process is consistent with the Government response to the NMHC report which indicated that 'Defence will increasingly target its efforts towards those most in need based on criteria such as continuity of healthcare, finding employment and social connectedness'. The intensive transition support services delivered to these at risk groups should be responsive to what veterans have identified as important needs. For example, the 2016 DVA client satisfaction survey asked veterans who had transitioned from the Defence Force in the last 5 years whether they had trouble accessing or finding support or services to help them. 45 per cent indicated that the main services for which they had trouble accessing or finding support were:

- physical health;
- finance support;
- mental health; and
- employment.[113]

6.98 The committee continues to see merit in Defence working with ex-service organisations to develop a transition mentoring program. This recommendation from the committee's Mental Health of Australian Defence Force Members and Veterans report should be reconsidered in the context of promoting and maintaining social connectedness for ADF members who are transitioning.

Recommendation 15

6.99 The committee recommends that the Department of Veterans' Affairs develop a two-track transition program for serving members leaving the ADF. Those identified as being in 'at risk' groups or requiring additional assistance due to their circumstances should be able to access intensive transition services. These intensive transition services should include additional support:

- **claims case management;**
- **healthcare, mental health and wellbeing support;**
- **employment assistance programs;**
- **social connectedness programs; and**
- **health and wellbeing programs.**

113 DVA, *2016 Client Satisfaction Survey*, May 2017, p. 19.

Provision of DVA White Cards

6.100 The committee considers that, in the context of the expansion of the non-liability health care to all mental health conditions, every ADF members leaving service should be provided with a DVA White Card (which facilitates use of these services). While many veterans will never seek to use the non-liability health care services available to them, their DVA White Card will serve a purpose by highlighting a pathway to assistance for veterans. Service-related mental health conditions may not present for veterans until many years after their service has concluded. The DVA White Card will be a physical indicator of the availability of support for each discharged ADF member that they can carry with them into civilian life.

6.101 The committee anticipates that future reform will further extend non-liability health care to veterans and the DVA White Card will be the key way veterans can access these additional services. The provision of DVA White Cards to all veterans would also serve as a veteran identification card which can be linked to their identification numbers, service record and medical records. This can be platform to facilitate data collection and tracking of health services used by veterans. Any veterans who requests it should be able to access a DVA White Card to use as a veteran identification card and to access non-liability health care.

Recommendation 16

6.102 The committee recommends the Australian Government issue all ADF members transitioning into civilian life with a DVA White Card.

6.103 While the ADF offers some opportunities for serving members in the transition period to undertake short term outside employment and gain on-the-job experience, the committee considers there could be further flexibility for veterans in these arrangements. The committee considers that an important addition to the existing Career Transition Assistance Scheme would be support for a paid period of work experience with outside employers. This would allow both the employer and the veteran to see if the prospective job opportunity was a good fit.

Veteran employment

Recommendation 17

6.104 The committee recommends that the Career Transition Assistance Scheme include an option for veterans to undertake a period of work experience with an outside employer.

6.105 The valued skills and experience of ADF members mean they are often well suited to other public sector careers. Other nations actively support veterans, and particularly veterans with disabilities, through preferences in public sector employment. For example, in the United States, veterans make up a substantial portion of federal government employees. To compliment the efforts to increase veteran employment in the private sector, the committee considers there should be an examination of other specific mechanisms to increase the participation of veterans in public sector employment. The committee notes that the APSC will include specific information for veterans seeking employment in the APS and launch an online tool for aligning ADF ranks to APS classifications in 2017. A further APSC review should

focus on other active measures which could be undertaken to support veteran employment in the APS and the public sector more generally. This could include a formal preference for veterans where applicants are equally ranked.

Recommendation 18

6.106 The committee recommends that the Australian Public Service Commission conduct a review into mechanisms to further support veteran employment in the Australian Public Service and the public sector.

Support for partners

6.107 Significant support for the families of veterans exists through the services provided by the Defence Community Organisation and the VVCS. The committee welcomes the recognition of the importance of families of veterans expressed by Defence and DVA. A supportive and inclusive approach to the families of veterans in the transition process is vital to ensuring the long-term well-being of veterans.

6.108 However, a consistent theme from the evidence received was that there was a lack of support for the partners those veterans who have mental health conditions or have acquired severe disabilities arising from their service. The partners of veterans often act as the keystone of support for veterans, some as full-time or part-time carers. The situation of veterans often markedly declines when these relationships fail. In the view of the committee, this is a critical area for DVA to investigate and develop further measures of support.

Recommendation 19

6.109 The committee recommends that the Department of Veterans' Affairs review the support for partners of veterans to identify further avenues for assistance. This review should include services such as information and advice, counselling, peer support and options for family respite care to support partners of veterans.

6.110 The committee was also concerned to receive evidence regarding the challenges which may face veterans moving from DVA support into aged care. It was apparent that loss of access to services such as Veterans' Home Care and the Rehabilitation Appliances Program could have serious implications for elderly veterans transitioning to aged care. Although this was not a focus during the inquiry, the committee notes the importance of this issue given the large number of elderly veterans.

Chapter 7
Other related matters

Introduction

7.1 The terms of reference of the inquiry were far-reaching and a wide range of topics were raised with the committee. This chapter will address a number of these other related matters. These include:

- alternative and complementary therapies;
- coordination and awareness;
- recruitment and resilience;
- advocacy issues; and
- appeals from DVA decisions.

Alternative and complementary therapies

7.2 Potential efficacy of alternative non-clinical therapies for veterans who may have mental health conditions related to their service was repeatedly highlighted to the committee. These included yoga, meditation, assistance dogs, equine therapy and medicinal cannabis. For example, Adore Yoga considered there was 'overwhelming evidence in the literature that the most effective intervention in the treatment of PTSD includes yoga and meditation'.[1] Mr Russel Ward from Ruff Love Assistance Dogs told the committee about the benefits of assistance dogs for veterans with mental health conditions:

> If a veteran was to lose a leg and could not walk anymore, DVA would give them a wheelchair. I have been given PTSD as a description, and they will not give me anything—all I get is some drugs and a psych. I think the dogs have changed a lot of lives, and we have certainly got testimonies through our veterans and through families. They ring Ricky or someone along those lines and say: 'You've saved my husband. He was on the brink of taking his own life, and now he's turned around because he's got a dog.' Dogs are not judgemental. They will love you unconditionally.[2]

7.3 The argument was made that DVA should do more to incorporate these treatments and activities into supports available to veterans. For example, RSL DefenceCare recommended that 'DVA should research non-clinical treatment options, their cost and benefits and allow more flexibility and client choice in what is achieving the best outcomes'. It stated:

> Currently, DVA's model of acceptable treatments is primarily based on clinical options, many of which are expensive and require additional clinical options to counteract their effects (for example medication to

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1 *Submission 223*, p. 8.

2 *Committee Hansard*, 2 February 2017, p. 49.

> counter the side effects of other medication). Veterans are constantly telling us that they are better able to manage their injuries and illnesses through non-clinical treatments such as diet, equine therapy, assistance dogs, art, yoga, remedial massage, diet, and acupuncture other lifestyle or wellness type options. DVA will rarely fund any of these, yet they are improving the quality of life for many of our clients, have helped some reduce their reliance on medication, improve their self-esteem and increase the quality of their family relationships.[3]

7.4 Similarly, Mates4Mates believed it was 'important for DVA to be more flexible in considering emerging or complementary interventions in the treatment of PTSD and other military related psychological issues (e.g. Equine Therapy)'. It stated:

> While we entirely agree that any endorsed & funded service needs a strong evidence base, to date there seems to be an immediate dismissiveness of these new approaches. By the very nature of them being newer and emerging treatment options, there will obviously be a paucity of an extensive evidence base. Veterans Affairs agencies in the United States, Canada and the United Kingdom have proven to be far more open to funding pilot programs and initiatives to explore these types of approaches (Equine Therapy again as an example) so the evidence about their efficacy can be gathered. Mates4Mates would welcome a more flexible approach by DVA.[4]

7.5 The Joint Committee inquiry into the *Care of ADF Personnel Wounded and Injured on Operations* recommended that DVA 'accept complimentary therapies as legitimate treatment for psychological injuries if there is an evidence-based clinical reason to do so'.[5] The Australian Government supported this recommendation 'in principle'. However, it also noted:

> DVA undertook a comprehensive review of complementary therapies in 2010, and the evidence did not support extending coverage to services provided by complementary therapy providers under the Gold and White Card arrangements. The Government considers that, at the current time, there is not sufficient evidence available to support broader access to complementary therapies through DVA funded treatment arrangements.
>
> DVA funds the Australian Centre for Posttraumatic Mental Health to provide advice on emerging evidence on new treatment modalities for mental health, and is consulting with the Centre on the emerging evidence for potential adjunct therapies (such as art or music therapy) that could complement evidence-based treatment in the future.[6]

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3 *Submission 216*, p. 17.

4 *Submission 173*, pp 2-3.

5 Joint Committee on Foreign Affairs, Defence and Trade, *Care of ADF Personnel Wounded and Injured on Operations*, June 2013. 74.

6 Government response to Joint Committee on Foreign Affairs, Defence and Trade report, *Care of ADF Personnel Wounded and Injured on Operations*, December 2013, p. 4.

7.6 Similarly, DVA explained that it funded 'treatment on the basis of a clear evidence base in consideration of a fundamental duty of care to our client group; to ensure that treatment is safe and clinically effective; that treatment represents a cost-effective expenditure of public money; and that funding of treatment is consistent with the broader approach across government and the health care system'. It considered '[m]ost "alternative non-medical treatments" or alternative therapies do not presently have any reliable evidence-base to support the claimed clinical benefits'. It stated:

> In recent years, DVA has received a range of requests to fund alternative therapies on the basis of claims that they constitute treatment of mental health conditions, particularly PTSD. These have included assistance dogs, art therapy, equine therapy, gardening, trekking and bush retreats. All general requests of this nature are declined due to the absence of a reliable evidence base.[7]

7.7 However, while not specifically referring to alternative therapies, the RANZCP considered that it was important to 'acknowledge the limitations of evidence-based guidelines in policy development':

> Despite their importance in informing frontline treatments, it is important to recognise that a significant percentage of treatments are provided outside evidence-based guidelines, particularly when treating veterans with more severe comorbidities and chronic illnesses. Increasingly, the RANZCP is concerned that evidence-based guidelines may be being used to restrict services. A recognition of this significant issue appears to be missing in the policy approach, resulting in system deficiencies when addressing the needs of the more severely ill and disabled veterans.[8]

7.8 DVA highlighted that a Veteran & Community Grant may be available to support an organisation to undertake activities which support the well-being of veterans. Further, DVA provides rehabilitation programs which can support a range of activities appropriate to a veteran's needs:

> These may be psychosocial activities, which aim to improve life management skills, health self-management skills, social connectedness and meaningful engagement with family and the broader community. A rehabilitation program therefore may include, for example, short term yoga or meditation courses, illness-self management programs, or community/adult education courses such as music, art, or photography.[9]

7.9 In relation to assistance dogs, DVA differentiated between service dogs and companion dogs. DVA provides funding for service dogs where the client meets the criteria for eligibility and clinical need and where a service dog is considered the most cost effective and clinically appropriate option. However:

> DVA does not fund companion dogs, such as for the treatment for mental health conditions, due to the lack of research based evidence. Overseas

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7 DVA, response to written question on notice from 6 February 2017 public hearing.

8 *Submission 165*, p. 3.

9 DVA, response to written question on notice from 6 February 2017 public hearing.

> studies into the effectiveness of companion dogs in helping people with mental health conditions, including one by the US Department of Veterans' Affairs, may assist in addressing this evidence gap. DVA is closely monitoring the progress of the US study, which is due for completion in 2018.[10]

7.10 DVA has outlined that it is 'maintaining a watching brief on existing international research regarding the clinical efficacy of assistance dogs in treating veterans' and will 'continue to be informed by the literature and national and international experts regarding the appropriateness of these interventions into the future'.[11] A joint project is currently being undertaken between Royal Society of the Blind's Operation K9 and the University of Adelaide that aims to examine the longitudinal impact of the Operation K9 Assistance Dog Program on participants' health and wellbeing.[12] A study being conducted by the US Department of Veterans' Affairs has been temporarily halted and no conclusions are expected to be released until 2020.[13]

Recruitment and resilience

7.11 The annual recruiting targets for Defence Force Recruiting (DFR) averages around 8,000 per year. The recruitment assessment process includes Defence interview, psychological interview and a medical assessment (by a Doctor) to determine suitability and readiness. Defence stated:

> Entry medical standards are agreed by each of the Services. Since 2008 these have been contained in the *Defence Health Manual*, which requires strict application of those standards.
>
> A past suicide attempt and/or current psychiatric condition are both current exclusion criteria for DFR. Mental health issues are explored in both medical and psychological assessments. In addition, the DFR psychological interview also examines other aspects of psychological suitability for service, including maturity, educational and employment history, interpersonal skills, motivation for military service, resilience, and adaptability to military employment.
>
> The standards vary depending on the underlying condition, current functioning and future risk, and are informed by psychiatrists and current clinical evidence. The entry medical standards in general are conservative in the mental health space, as military service places stressors that increase the risk for depression and anxiety on individuals (known factors which increase the risk for depression or anxiety symptoms include regular moves, regular job changes, removal from social and family support, removal from access to health support, fatigue and altered work hours often involving

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10 DVA, response to written question on notice from 6 February 2017 public hearing.

11 DVA, response to questions on notice 10, Budget estimates, 30 May 2017, p. 2.

12 Centre for Traumatic Stress Studies, 'Military research', available at http://health.adelaide.edu.au/ctss/research/military/ (accessed 11 August 2017).

13 Ms Lisa Foreman, DVA, *Committee Hansard*, Budget estimates, 30 May 2017, p. 150.

> shift work and disturbance of circadian rhythm and exposure to potentially traumatic events).[14]

7.12 Defence acknowledged that, as assessments rely on candidates accurately reporting their medical history, inclusive of mental health, there was potential for under-reporting. It noted this risk was mitigated by a number of factors including assessments being conducting by at least three experienced health practitioners (doctors, nurses and psychologists) and candidates signing statutory declarations.[15]

7.13 The NMHC report recommended that '[t]he widespread perception that deficiencies exist in the recruitment processes for Defence should be further examined utilising a rigorous methodology to ascertain whether there are points of weakness in the current processes that may lead to unsuitable candidates being accepted for service'.[16] In relation to this recommendation, the Australian Government responded:

> The quality of processes and decision making within Defence Force Recruiting is of a high standard and is regularly assessed. The Services reaffirmed in 2016 and 2017 that the risk tolerance in recruiting with respect to mental health assessment was appropriate and should be maintained. The processes and decision making within Defence Force Recruiting will continue to be reviewed regularly, to confirm they remain appropriate and align with requirements and expectations of the Services. A targeted communication strategy is being developed to inform key Defence personnel regarding Defence Force Recruiting, the contract framework, the delivery of recruiting services and the level of Commonwealth oversight in place.[17]

7.14 Recruitment practices and appropriate resilience training were also issues raised by submitters to the inquiry. Mr Ken Park recommended that 'the psychological testing of recruits and the process of allocation to trade/corps be reviewed in order to better identify those unsuitable for combat roles'. Further, he considered the 'training of servicemen should include some exposure and desensitising to death and injury'.[18]

7.15 ADSO argued for a more holistic approach to resilience-building for ADF members and that resilience support should continue into civilian life. It recommended identifying a 'Defence-DVA resilience pathway that includes in-service resilience training, transition, rehabilitation, Non-Liability Health Care and VVCS'.[19] Similarly, Mr Max Ball suggested the committee consider whether 'resilience needs to be a key factor in selection' and 'whether training for people in the ADF should take into account specific matters of training which improve resilience'.[20]

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14 *Submission 124*, Supplementary submission, p. 2.

15 *Submission 124*, Supplementary submission, p. 4.

16 NMHC report, p. 53.

17 Government response to NMHC report, p. 69.

18 *Submission 19*, p. 5.

19 *Submission 172*, p. 7.

20 *Committee Hansard*, 5 May 2017, p. 8.

> [L]ife in the military begins through recruit training which is designed to 'knock them down' in order to 'rebuild them' in a different mould…Recruits learn to unquestionably follow orders among the many other essential military skills and requirements in order to function within the organisation. In effect members are deliberately institutionalised with an emphasis on high levels of personal discipline, a sense of belonging and elitist mentality.[21]

Coordination and awareness of services

7.16 There are complex range of services and programs that veterans may be able to access. These include services from DVA and other federal agencies as well as supports such as mental health and suicide prevention programs which exist in each state and territory jurisdiction.[22] Mr Simon Lewis, the Secretary of DVA, identified 'one of our gap areas is that we really did not have a broader relationship with the state or territory governments at all'.[23] In this context, on 25 November 2016, there was an initial meeting of ministers responsible for Veterans' Affairs from federal, state and territory governments. The Ministers agreed:

- that each state and territory would work with the Commonwealth to develop standardised military service history indicators to use in national and jurisdictional data collections for suicide and homelessness. This will improve the quality of data collected and lead to better service delivery.
- to pursue inclusion of a military service related question in the next Census to greatly improve our understanding of the veteran community.
- the Commonwealth will investigate a mechanism to advise states and territories when Australia Defence Force (ADF) personnel are medically-discharged to help better plan the provision of support services.
- the Commonwealth will ensure that all medically-discharged veterans have a Medicare card when they separate from the ADF.
- New South Wales, Victoria, Western Australia and South Australia are collecting data on veteran incarceration and all other states and territories have agreed to explore collecting this data.
- New South Wales and Victoria have specific programs to address veterans' homelessness, and information on these programs will be shared with all other states and territories.

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21 Name withheld, *Submission 242*, p. 3.

22 For example, Mr Stan Piperoglou, Suicide Prevention Australia, *Committee Hansard*, 19 November 2016, p. 27.

23 *Committee Hansard*, 6 February 2017, p. 59.

- state and territory governments will provide information on their services as part of every ADF transition session for personnel leaving the military.[24]

7.17 ESO's also provide a broad range of services to veterans. For example, the RSL South Australia noted that it provided 'advocacy services for veterans claiming entitlements with DVA; social welfare in the form of rent, utility, vehicle expenses, education expenses and food vouchers; assistance for veterans with PTSD via peer-to-peer counselling and Operation K9 assistance dogs; crisis homeless accommodation services with Homes for Heroes; and reintegration and reconnection programs with RSL Active'.[25] Similar, Mr Sauer from Mates4Mates explained the five streams of services provided to veterans through that ESO. These included physical training, psychological support, rehabilitation challenges, employment and education and social engagement.[26]

7.18 Some perceived the need for better coordination and collaboration between DVA and ESOs. For example, Mates4Mates thought 'that positive collaboration is happening between ESO and DVA in some pockets…[but] there is scope for more direct & practical collaboration to occur'. It suggested that '[m]ore formalised and regular opportunities for collaboration will allow many ESO's, particularly the smaller ones, to be in a better position to assist with dispelling myths and help create more positive experiences of the DVA process for veterans'.[27]

7.19 Bravery Trust provided an example of how DVA and ESOs could provide tailored and coordinated support to veterans:

> When a liability claim is submitted to DVA and the DVA case manager calls the veteran to commence the process, they should make a judgement about whether the veteran is or could be in financial hardship. If the veteran appears to be in a position of financial hardship a referral to Bravery Trust should be made immediately. Bravery Trust was specifically established to be a financial safety net in these circumstances.[28]

7.20 The challenges for veterans seeking support to find appropriate services were highlighted during the inquiry. Brigadier Hanna from the RSL SA noted that '[t]here are all sorts of organisations seeking to do good work and achieve many good things, but it is quite a maze to navigate…'.[29] Professor Andrea Phelps from Phoenix Australia considered there was a lack of a 'coherent process for people to navigate that system':

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24 The Hon Dan Tehan MP, 'Cooperation on veterans' issues', *Media release*, 25 November 2016.

25 Mr Julia Langrehr, *Committee Hansard*, 17 November 2016, p. 46.

26 *Committee Hansard*, 2 February 2017, p. 50.

27 *Submission 173*, p. 4.

28 *Submission 170*, p. 4.

29 *Committee Hansard*, 17 November 2016, p. 50.

> It is a little bit hit and miss: depending on where you happen to go for help first might determine whether you get into a PTSD program or whether you get help for your family member. Again, there is probably no simple solution to this, but if everyone in the service system understands and is aware of their role and how that fits with all of the other components of the service system—if there is a map that is available for people to actually see how all of that fits together—that would be of great assistance in getting a more consistent approach so that people do get access to the services that they want. Whether that is a single point of entry or whether it is just that everyone knows who all of the other players are and what they have to offer—that it is not seen as a competitive system between those various components, but that it is very much a collaborative approach.[30]

7.21 Similarly, Solider On commented:

> The maze of services, programs, entitlements and subsidies serves to confound and overwhelm veterans and their families leaving them feeling like they are confronting the night sky, as one spouse of a veteran told Soldier On, "[T]here are many bright shiny places to go, but out of the hundreds of options, where are we meant to go? What we need is a map, we don't need more stars".[31]

7.22 Mr Briggs from Slater and Gordon Lawyers highlighted the confusing variety of services available to veterans:

> These groups are attempting to deliver Veteran-specific care but it appears there is now, like in the US and UK models, a plethora of different approaches, interventions, philosophies and possible outcomes. I would suggest the sheer variety of solutions may in some cases only cause greater confusion amongst Veterans with psychological injuries, but we would defer this issue to the medical specialists for further comment. I can advise that one size does not fit all and many of my clients report being confused by the multitude of available services. They do not know where or who they should turn to for their specific needs. Furthermore, this overlapping means many organisations are actively competing against each other for funding. Public donations are being spread over the multitude of existing support groups and service providers.[32]

7.23 Mr Briggs proposed 'a clear and concise mapping of the numerous organisations within the ADF support field for Veterans and their families and where necessary, consolidation of particular groups so that Veterans may be adequately supported by the services available to them and to avoid the wasting of resources'.[33]

7.24 Bravery Trust also perceived need for ESOs to enter a reform process consistent with the Veteran Centric Reform agenda of DVA. It stated:

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30 *Committee Hansard*, 2 February 2017, p. 63.

31 *Submission 175*, p. 7.

32 *Submission 160*, p. 15.

33 *Submission 160*, p. 29.

> Duplicating or replacing services provided by others is wasteful. Looking to the past for a vision of successful veteran centric delivery will not introduce the change necessary. Fresh, agile and innovative service delivery models are required between ESOs. Bravery Trust believes that this will inevitably lead to consolidation of service delivery by ESOs as well as ESO consolidation itself.[34]

7.25 Mr Johnson proposed DVA should work to develop a services portal for veterans and their families which better outlines the range of support services available to veterans and which enables veterans to better access point-in time data about the status of their claims and case details.[35] Along the same lines, Mr Ventham suggested a national publicity campaign for an information hub, so veteran family members and friends knows where assistance for veterans is available. He stated:

> Help does exist for people in the veteran community who know where to look but information is fractured and services are poorly publicised. An ongoing and major publicity campaign should not be quarantined to veteran communities. A one-stop web portal and helpline – independent from the Department of Veteran Affairs should be properly funded so every contact from family and friends can be followed up and veterans in crisis can be triaged and referred to appropriate help services in their area.[36]

7.26 The NMHC report recommended that the ADF and DVA should consider 'how to better promote the services that are available to current and former serving members and their families so that awareness of the range of services and how to access them is increased'.[37] The Australian Government response noted that 'DVA and Defence have a number of mechanisms in place to promote their services and will continue to utilise and expand on these mechanisms'. In particular, it highlighted:

> An advertising campaign is underway to promote access to mental health services for veterans without the need to submit a claim for compensation through non-liability health care arrangements. This campaign will include online media to particularly target at-risk young men.[38]

Advocacy

7.27 From 1 July 2016, the Advocacy Training Development Program (ATDP) replaced the previous Training Information Program (TIP) for advocates for veterans. The ATDP introduces a nationally accredited competency based training program in compensation and welfare for advocates. DVA outlined:

> The ATDP will introduce a nationally consistent learning framework (courses, assessment, Recognition of Prior Learning, accreditation) based on advancements in learning and development practices, supported by on

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34 *Submission 170*, p. 4.

35 *Submission 264*, p 6-7.

36 *Submission 295*, p. 13.

37 NHMC report, p. 53.

38 Government response to NMHC report, p. 69.

> the job training and mentor support. The ATDP will also establish a Community of Practice, a network of advocates and community members who support one another within a city or region, which will encourage collective learning and knowledge sharing…
>
> The ATDP will help to alleviate the mental health concerns of current and former serving ADF members and their families around accessing their entitlements by ensuring, through high quality advocacy services, that their claims are not delayed through inaccurate advice or incomplete claims. Into the future, current and former serving ADF members and their families will have access to a list of accredited advocates who they can choose from to give them advice and assist them in accessing their entitlements.[39]

7.28 Advocacy and welfare support to veterans is provided through partnership arrangements between the DVA and the ESOs. Key programs include:

- Building Excellence in Support and Training (BEST) Grants Program;
- Veteran and Community Grants (V&CG) Program; and
- the Veterans' Indemnity and Training Association (VITA).

7.29 In particular, the Building Excellence in Support and Training (BEST) grants program supports ex-service organisations (ESOs) to provide compensation and welfare assistance to the veteran and Defence community. Ms Lisa Foreman, First Assistant Secretary, Rehabilitation and Support at DVA explained:

> The funding for BEST is worked out according to a formula, which has been agreed with the ESO round table. The formula picks up the number of advocates an ex-service organisation has, as well as the type of work that those advocates do and the number of cases that they have had…We spend $3.8 million on the Building Excellence in Support and Training and $1.2 million on the Advocacy Training and Development Program.[40]

7.30 A DVA *Review of DVA-funded ESO Advocacy and Welfare Services* in 2010 found that the 'Australian model whereby ex-serving members voluntarily take on a role to assist in claims preparation is one that to date has worked very well and should be continued'.[41] However, significant concerns were raised during the inquiry regarding the future of the current advocacy model.

7.31 A large portion of the volunteer advocates which the system relies on are from an older age group. The Aspen Foundation ESO Mapping project found:

> Just over half of the ESO pension support workforce capability (51% of TIP Pension Officers, and 58% of volunteer VRB advocates), are 68 years of age or older.

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39 *Submission 156*, p. 16.

40 *Committee Hansard*, 6 February 2017, p. 58.

41 DVA, *Review of DVA-funded ESO Advocacy and Welfare Services*, December 2010, p. 85.

> With a 10 year planning horizon, most of those volunteer pension officers and VRB advocate volunteers will not be as active in 10 years' time as they are now, thus reducing the capacity of this national capability.
>
> Significant effort is required to ensure there is another generation of volunteers being recruited, trained and mentored (while they gain experience) to continue this important work.[42]

7.32 The RSL emphasised that the thousands of volunteers, advocates, pension officers and welfare officers were as an essential element of the system and necessary for veterans to deal with the DVA. It noted:

> Like many other environments, the volunteers involved in this are overwhelmingly older, and not being replaced by adequate numbers of younger individuals. Both the decreasing number of volunteers and the complexity of supporting veterans with claims under the [MRCA] are creating the need for paid professionals to deliver advocacy and welfare services through agencies such as RSL DefenceCare.[43]

7.33 The prospect of an insufficient number of advocates in future was highlighted. Colonel David Jamison from the ADSO noted:

> [W]e have an ageing population of volunteer advocates, we have an increasing complexity in handling claims and we have a new, emerging system of training and accreditation of advocates. I see that the implementation of moving from the old to the new system is going to produce a gap in both numbers and expertise that, unless we are prepared to fund personnel to carry on that work, is going to be very difficult to handle.[44]

7.34 Mr Julia Langrehr from RSL SA noted that ESOs receive 'very little funding' for advocacy services 'certainly not enough to provide the service adequately'. Despite a busy advocacy workload for veterans in South Australia and the Northern Territory, RSL SA only had three paid advocates under the BEST funding program with the rest of the work being undertaken by volunteers.[45]

7.35 Mr Ball stated that 'the previous successful model of having volunteer advocates is now declining'. While he supported recent changes to improve the training and qualification of advocates through the ATDT program he described it as 'little bit too late or not enough'.[46] In particular, he noted that 'not all trained advocates are equally competent'. Mr Ball argued that previous discussed options for the employment of professional (paid) advocates 'required a higher level of discussion'.[47] He did not consider it was 'unreasonable for a veteran claimant to be given the option

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42 Aspen Foundation, *ESO Mapping Project Final Report*, 2016, pp 44-45.

43 *Submission 216*, p. 7.

44 *Committee Hansard*, 18 November 2016, p. 25.

45 *Committee Hansard*, 17 November 2016, pp 47-48.

46 *Committee Hansard*, 5 May 2017, p. 10.

47 *Submission 323*, p. 2.

of using a professional advocate, and making a financial (but not total) contribution to the cost of that advocate, or to seeking the help of a volunteer advocate'.[48] He stated:

> [M]y concern is that with the decline in volunteerism, the decline in numbers and the generation gap between what we call the pre- and post-1990 veterans the number of trained volunteer advocates will decline. We need new, younger advocates in an era where younger veterans, in my opinion, are seeking greater levels of competency in their advocates.[49]

7.36 Mr Ball also proposed that 'there is a need for the government to provide financial support to veterans who wish to employ para-legal or qualified lawyers to assist them when they enter the DVA claims process'.[50]

7.37 Some of the advocates the committee spoke with were overworked and cynical about DVA reforms to claim processing and advocacy training. For example, Mr Ken Parnell stated:

> Currently, I would say 30 percent of the advocates I know will not be continuing on because of the new alterations with TIP, which is the training system through DVA to ATDP. They have had enough.[51]

7.38 The stresses imposed on volunteer advocates were also raised. RSL DefenceCare stated '[t]he fact that DVA has allowed veterans who they classify as TPI and unfit for work (their clients who have known injuries and illnesses) to provide advice on complex legislation to others who are the DVA's potential clients and who are also potentially suffering physical and mental ill-health issues, without professional support is beyond comprehension, especially when we know the potential effects…'.[52]

7.39 Appropriateness of advocates representing veterans in all forums also was questioned. Mr Brian Briggs from Slater and Gordon Lawyers observed:

> To expect even a Level 4 advocate with no legal background to run a case in the AAT against a DVA retained private law firm engaging barristers is nothing short of a 'David vs. Goliath' battle. Advocates are not trained in running an AAT application on to Federal and High Court Appeals. DVA do not fund such legal training through BEST grants and TIP training. As a result of such overwhelmingly stacked odds in favour of DVA, the loser will ultimately be the Veteran.[53]

7.40 The training and expertise of advocates was also raised. Mr Anforth, a barrister, questioned the appropriateness of advocates routinely directing their clients to claim under the VEA:

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48 *Submission 323*, p. 2.

49 Mr Max Ball, *Committee Hansard*, 5 May 2017, p. 8.

50 *Submission 323*, Supplementary submission 1, p. 2.

51 Mr Ken Parnell, *Committee Hansard*, 17 November 2016, p. 28.

52 *Submission 216*, p. 20.

53 *Submission 160*, p. 41.

> These advisors are trained by the Repatriation Commissioner in the Department of Veterans Affairs. Their training is almost wholly directed to VEA with some MRCA but no SRCA…The lack of any knowledge on SRCA explains their failure to take veterans down that path. Their lack of knowledge on MRCA in part explains the lack of robustness in pursuing MRCA claims, including on appeal.[54]

7.41 Mr Anforth commented:

> Veterans' representatives are almost all well-meaning aging men who are trained by the DVA. They rarely have any legal background. Their age is relevant to their capacity to pick up and apply new legal concepts. Their lack of legal background is relevant to their confidence levels in taking issues with departmental lawyers and tribunal members. There is a tendency to go along with what is being said and just accept the outcome.
>
> This compliant attitude is fostered by the fact of being trained by the very people against whom they must advocate. Caesar is training Pompey in battle tactics. There is no quality control oversight of the advocate's performances.[55]

7.42 In this context, ADSO supported the introduction of the ATDP considering that it would move advocacy from 'enthusiastic amateurism' to a semi-professional practice:

> As a semi-professional practice, it will engage continuous learning and skill development. It will also challenge ESO executives to become involved in the selection and competency of the advocates they authorise to provide services to their members. Importantly, it will challenge the antagonisms and silo-mentality that has afflicted the ESO-DVA relationship for far too many years.[56]

Appeals

7.43 There are different levels of appeal pathways from compensation determinations under the three legislative schemes. Under the VEA clients may request an internal review and/or appeal directly to the Veterans' Review Board (VRB). If the client is then dissatisfied with the VRB decision, they may lodge an appeal with the Administrative Appeals Tribunal (AAT). From 1 January 2017, MRCA clients will have a single appeal pathway which aligns with the VEA. SRCA clients may request an internal reconsideration and, if dissatisfied, lodge an appeal with the AAT.[57] Appeals on points of law may be made to the Federal Court of Australia. DVA outlined:

> In 2014-15 there were 48,711 primary compensation determinations made under the [VEA], the [SRCA] and the [MRCA]. In the same period, 5,593

54 *Submission 208*, p. 8.

55 *Submission 208*, p. 13.

56 *Submission 172*, p.23.

57 *Submission 156*, p. 18.

> reviews and/or appeals were finalised by either Delegates of the Repatriation Commission or the Military Rehabilitation and Compensation Commission; the Veterans' Review Board (VRB) or the Administrative Appeals Tribunal (AAT). Of these reviews and/or appeals, 1,992 were set aside or varied.[58]

Veterans' Review Board

7.44 The Veterans' Review Board (VRB) is a specialist tribunal whose role is to provide independent merits review of decisions made by the Repatriation Commission under the VEA and the Military Rehabilitation and Compensation Commission under MRCA. The VRB considers approximately 2,900 applications for review each year. In the financial year 2015-16, the VRB set aside 48.7 per cent of the appeals. The average time taken to decide an application by the VRB was 51 weeks. 6.6 per cent of applications were appealed to the AAT.[59]

7.45 The VRB's governing legislation encourages veterans, current serving member or their dependants to present their case without for legal representation. At the VRB, over 85 per cent of applicants (that is the veteran, current serving member or their dependant) are represented, but usually by a non-legally qualified volunteer or professional paid advocate from an ESO.[60]

7.46 The VRB also has a 'Fair Hearing Obligation' in place. The fair hearing obligation sets out that VRB has a duty to ensure the right to a fair hearing including the provision of a reasonable opportunity for applicants to put their case - the right to be heard - and for the case to be determined to law by a competent, independent and impartial panel of members of the VRB. The VRB stated:

> The provision of a fair hearing requires Members of the VRB to identify the difficulties experienced by any party, whether due to lack of representation, literacy difficulties, ethnic origin, religion, disability or any other cause, and find ways to overcome those difficulties and assist them through the VRB processes.[61]

7.47 Mr Douglas Humphreys, Principal Member of the VRB, highlighted the benefits of the recently introduced Alternative Dispute Resolution (ADR) program and a process for directions hearings. In particular, he noted that where matters go to ADR process 'just about 60 per cent' are resolved with 12 weeks.[62]

7.48 The Dunt review in 2009 commented that 'in general' the VRB works well, however found it surprising that 'a tribunal that is not adversarial in its approach and excludes lawyers from representing veterans, is so oriented to the law'. It noted that material for consideration is prepared by 'prepared by DVA legal staff or contract

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58 *Submission 156*, p. 18.

59 VRB, *Annual report 2015-16*, p. 11.

60 *Submission 122*, pp 2-3.

61 *Submission 122*, pp 3-4.

62 *Committee Hansard*, 6 February 2017, p. 16-17.

lawyers' and 'almost half of VRB members have legal backgrounds'. It observed veterans 'will either be unrepresented or if they are represented, will be represented by a volunteer advocate from an ESO'.[63]

7.49 The VRB noted that the restriction on lawyers was first introduced followed lobbying by ESOs and it was 'intended to prevent appeal hearings from becoming overly adversarial, technical and resource intensive'. It considered the prohibition continued to enjoy the support of most ESOs and noted that applicants are still able to consult lawyers prior to their hearing.[64]

7.50 Some submitters considered the rule against legal representation should be reconsidered. For example, Mr Max Ball described the situation as 'one-sided'. While there was 'nothing to prevent a veteran from receiving advice from a lawyer prior to a VRB hearing', he emphasised the stress caused to veterans 'by being denied by the government of having legal representation in a hearing', and 'perhaps being questioned themselves by a lawyer'.[65]

7.51 The Dunt review also highlighted that 'only a few VRB members have mental health, counselling or even medical backgrounds':

> This is surprising given that the VRB is asked to reconsider the medical and mental health material based upon the application of epidemiology and evidence based medicine in the form of the SoPs. It is important to appreciate the strengths but also the discretion needed in the interpretation of the SoPs and their application. This will be difficult for a person with a non-medical or non-clinical background.[66]

7.52 The VRB outlined:

> Our members have diverse qualifications and experience including specialist expertise that we draw on as needed, such as when hearing cases that involve psychological or mental health issues. There is tri-service representation, meaning members from all three arms of service are available to sit on hearings. Additionally, more than 40% of the VRB's members are female. As such, the VRB can convene all female panels for particularly sensitive appeals, where requested by an applicant.

7.53 RSL SA noted its advocates attended between 8 and 15 VRB proceedings per month dealing with large case files (sometimes in excess of 400 pages). While describing the VRB as generally 'very fair', it noted the burden on advocates preparing for the VRB.[67] Some veterans described their experiences at the VRB negatively. A name withheld submission from a female veteran disagreed 'with the recent decision to uphold the practice of not allowing lawyers at the VRB'. She stated:

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63 Dunt review, p. 87.

64 *Submission 122*, p. 2.

65 *Submission 323*, Supplementary submission 1, p. 2.

66 Dunt review, p. 87.

67 Mr Justin Brown, *Committee Hansard*, 17 November 2016, p. 49.

> If veterans were professionally represented, there would be a decrease in the number of VRBs because sounds decision would be made earlier. I believe The Department exploit[s] the sub-standard representation unfortunately offered by many ESO groups…Veterans are effectively participating in complex cases of Commonwealth Law, against The Department and its might of resources, without any legal representation. ESO advocates also discourage veterans from using lawyers. This is so unhelpful…
>
> I attended the VRB with a big black eye. The OAM advocate who flew to represent me said nothing. The all-male panel that I sat before in the VRB said nothing. I felt completely disempowered, embarrassed and totally unrepresented. We presented no new evidence to progress any of the claims and could not answer questions to clarify my arguments, nor could I confidently articulate myself. There was no female panel member. It felt like an extension of the Defence Disciplinary System. My welfare was literally ignored.[68]

7.54 Mr Anforth perceived disadvantages for veterans 'in the nature of the review and appeal systems'. He noted that in appeals to the VRB:

- the veteran is not entitled to legal representation;
- the veteran usually has no money to obtain their own specialist reports to support their claims, including the medical causation issue i.e. the linkage of the injuries to service; and
- if the veteran does commission their own specialist report or subpoena a medical witness for their case they must bear the cost.

7.55 He characterised this situation as an 'unfair and unequal contest' and described the VRB has having a poor record of upholding veteran claims.[69]

Administrative Appeals Tribunal

7.56 The Administrative Appeals Tribunal (AAT) conducts independent merits review of administrative decisions made under Commonwealth laws. The Veterans' Appeals Division of the AAT handles applications for review of decisions under the VEA, MRCA and SRCA. Parties in the AAT are entitled to be represented by another person. The majority of applicants in the veterans' affairs jurisdiction before the AAT are legally represented which reflects the fact that there is greater access to legal aid and cost recovery in relation to veterans' affairs cases.

7.57 The AAT aims to finalise applications within 12 months of lodgement and in 2015-16, 66 per cent of Veterans' appeals applications were finalised within this period.[70] The AAT does not have a general power to award costs and the usual position is that parties must bear their own costs.

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68 *Submission 292*, pp 6, 9.

69 *Submission 208*, p. 9.

70 *Submission 127*, p. 4.

7.58 The AAT finalised 288 applications for review of decisions of the VRB in 2015-16. The AAT varied or set aside the VRB's decision in 154 applications (53 per cent). In three of the 154 applications, the applicant was the Military Rehabilitation and Compensation Commission seeking review of the VRB's decision. The claimant was the applicant in relation to all other applications.[71]

7.59 Some veterans recounted personal experiences of extreme distress related to AAT hearings.[72] The AAT Registrar, Ms Sain Leathem acknowledged 'the comments of sufferers of post-traumatic stress disorders who are self-represented before the AAT that they have found the law complex and the hearing process stressful'. She stated 'AAT will consider these comments regarding its delivery of services to this applicant group'.[73]

7.60 Mr Anforth highlighted that legal costs were a deterrent to veterans seeking review of decisions through the AAT. In particular, in practice legal aid was not available to veterans:

> Even if the veteran is successful in the AAT there are no costs awarded to the veteran. This means that any lawyer acting for the veteran cannot expect to be paid from a costs order for their fees or the cost of medical reports. The veteran needs to personally fund the matter, win or lose…
>
> The AAT Act and the Attorney General's website both assert that grants of legal aid are available to assist veterans appealing from the VRB to the AAT. This is simply not true. There are no such hypothecated funds for veterans.[74]

7.61 Due to these and other systemic disincentives, Mr Anforth noted that 'hardly any appeals flow from the VRB to the AAT'. He described the VRB as 'a de facto glass ceiling for veterans' claims'.[75] Mr Anforth stated:

> This threat of legal costs from the Commonwealth is a major disincentive for veterans to appeal any adverse decision from the AAT or to attempt to defend any appeal from the Commonwealth. It is even a disincentive for the veteran to run a case in the AAT for the reason that if the veteran spends the money to do so and wins in the AAT, the Commonwealth may only appeal the decision to the Federal Court which the veteran cannot then afford to defend.[76]

7.62 Mr Anforth noted that legislated assistance to assist claimants have not 'been indexed or otherwise kept pace with changing cost structures'. He proposed that the *Federal Proceedings (Costs) Act 1981* should be amended to shield claimants from

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71 AAT, response to question on notice from 6 February 2017 public hearing.

72 For example, Mr David Kalman, *Submission 54*, pp 2-3.

73 *Submission 127*, p. 1.

74 *Submission 208*, p. 10.

75 *Submission 208*, p. 11.

76 *Submission 208*, Supplementary submission 1, p. 1.

legal costs. He noted that this problem also affected non-military Commonwealth employees under the SRCA.[77]

7.63 Similarly, Mr Briggs argued that the 'barriers imposed against the award of costs for a successful Veteran in the Administrative Appeal Tribunal (AAT), means that while Veterans are strictly entitled to legal representation at this stage, this will in practice see many denied that opportunity due to resource constraints'.[78] The VVFA outlined:

> Initially, at appeals before the AAT, DVA provided lawyers from their own Legal Branch to put their case at the hearing. Level 4 Advocates from the VVFA and other ESOs who had received a week's training would represent the veteran on these occasions. This was a satisfactory arrangement in most cases.
>
> In recent years DVA have retained large national law firms such as Sparke Hellmore to present their case to the AAT. A barrister would then be briefed to represent DVA at the Tribunal. Notwithstanding, the veteran would still be represented by a Level 4 Advocate, leading to a most uneven, unfair and most unsatisfactory process.
>
> If a veteran wants to retain a solicitor or barrister, then the veteran needs to pay. DVA maintain that a veteran can get Legal Aid, but it is the case that the Federal Government has slashed hundreds of millions of dollars from the Legal Aid budget, and States and Territories tend to fund cases with the possibility of gaol. Cases involving veterans' appeals have no priority. Veterans used to have a percentage of the legal aid allocated to States and Territories for their exclusive use, but this no longer pertains.[79]

7.64 VVFA considered that there was a need to provide free and expert legal representation for veterans in the appeal process. It suggested:

> The Bureau of Pensions Advocates (BPA) within Veterans Affairs Canada is a unique, nation-wide organization of lawyers that provides free legal help for people who are not satisfied with decisions about their claims for disability benefits. This model would address the legal imbalance currently occurring in veteran appeals in Australia.[80]

7.65 In response to this issue, DVA stated that it and its legal representatives 'do not use the issue of legal costs to dissuade veterans from pursuing appeals regarding their entitlements':

> Generally, before the AAT each party bears their own costs, although under section 67 of the [SRCA] and section 357 of the [MRCA], the AAT may in specified circumstances order that the Commonwealth pay the costs of the veteran claimant. There is no scope under the [VEA] for the AAT to order

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77 *Submission 208*, Supplementary submission 1, p. 2.

78 *Submission 160*, p. 34.

79 *Submission 277*, pp 13-14.

80 *Submission 277*, p. 15.

> the Commonwealth to pay the veteran's costs. However, it is noted that veterans may be able to access legal aid in the review of specified VEA decisions before the AAT without having to satisfy a means test.[81]

7.66 The AAT provided the committee with statistics on types of representatives in Veterans' Appeals in 2015-16.[82]

Role	Party Type	Representative Type	Total
APPLICANT	Individual	Representation type not known	3
APPLICANT	Individual	Private Solicitor/Legal Firm	192
APPLICANT	Individual	Community Legal Centre	1
APPLICANT	Individual	Self-Representative	62
APPLICANT	Individual	Legal Aid	5
APPLICANT	Individual	Barrister	1
APPLICANT	Individual	Friend/Relative	6
APPLICANT	Individual	Other non-legal advocate/organisation	62
OTHER	Agency	Private Solicitor/Legal Firm	1
RESPONDENT	Agency	Self-Representative	233
RESPONDENT	Agency	Private Solicitor/Legal Firm	111
RESPONDENT	Agency	Representation by other agency (e.g. Centrelink)	1

Issues

7.67 The view that DVA had an adversarial approach to claims was repeated in relation to appeals. Dr Andrew Khoo restated a previous submission he had made in 2012:

> The majority of veterans and advocates (whom I have contact with) impression is that a steadily increasing proportion of claims seem to be proceeding to the Veterans Review Board and the Administrative Appeals Tribunal, which indicates that the DVA are looking for reasons not to provide compensation rather than ways to support their clients.[83]

7.68 DVA noted that it must comply with the Attorney-General's *Legal Services Directions 2005*, incorporating the Commonwealth's obligation to act as a model litigant in the conduct of all litigation. However, several submitters questioned whether DVA or their lawyers were consistently acting as model litigants.[84] Mr Peter Larter, an advocate, described a 'terrible culture within DVA' and instances of bullying, intimidation and 'blackmail by the contracted law firm that DVA use' against advocates.[85]

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81 DVA, response to written question on notice from 6 February 2017 public hearing.

82 *Submission 127*, p. 2.

83 *Submission 155*, p. 6.

84 For example, VVFA, *Submission 277*, p. 14.

85 *Committee Hansard*, 5 May 2017, p. 12 and 16.

7.69 The AAT stated that in the period from 1 July 2015 to 6 February 2017, the Tribunal did not approach the Department of Veterans' Affairs with any concerns about the conduct of its representatives in veterans' entitlements and military compensation cases. However, it also noted that 'one decision was published in this period in which a member of the AAT stated that he felt certain conduct may not have been consistent with the model litigant obligations'.[86]

7.70 Others felt that DVA were wasting resources in defending appeals. For example one veteran objected to the 'extraordinary amounts of taxpayer money spent on AAT lawyers, and the time spent on VRB, and by DVA and clients, only to have the cases overturned with barely any effort except for wasted time and money'. He noted that he had experienced 'DVA lawyers twice roll over on the actual day of both AAT hearings… this means that no case law was published, and therefore cannot be used in another case as a precedent'.[87] Mr Peter Reece described the framework of appeals to the VRB, AAT and the Federal Court as 'just crazy' noting that 'people get worn down':

> They cannot handle the legalisms of it. The legal fraternity cannot cope with it. It is just a shambles. If you persist and you have the right sort of assistance from the ex-service organisations, where people know this complex system, you will get there in the end, but it could take years, and that kills people. It completely breaks them down. It ought to be quick, it ought to be transparent and it ought to be a meeting. It is none of those things.[88]

Committee view

7.71 The committee received compelling evidence from veterans with mental health conditions and those that support them concerning the benefits of a range of alternative therapies. They felt that these alternatives therapies had significantly improved their conditions. Several gave evidence that their lives had been saved through having access to these treatments.

7.72 While the committee accepts the position the evidence base is still developing in relation to many of these alternative therapies, several are already being provided through ESOs and other groups to veterans. In the view of the committee, there is scope to expand and reshape existing programs to take into account the provision of several alternative therapies to veterans. In particular, the Veteran and Community Grants program provides funding for projects that support activities and services to sustain or enhance health and wellbeing of veterans.

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86 AAT, response to question on notice from hearing 6 February 2017.

87 Name withheld, *Submission 306*, p. 15.

88 *Committee Hansard*, 5 May 2017, p. 23.

Recommendation 20

7.73 The committee recommends:

- **the Australian Government expand the Veterans and Community Grants program to support the provision of alternative therapies to veterans with mental health conditions; and**
- **the Department of Veterans' Affairs consult with ex-service organisations and the veteran community regarding avenues to reform the Veterans and Community Grants program to support the provision of alternative therapies to veterans.**

7.74 The committee also sees value in ensuring that an evidence base for supporting the use of complementary treatments, such as the effectiveness of companion and assistance animals, is developed. The committee believes that to ensure clear and relevant evidence is being gathered these research projects should be delivered and conducted within Australia.

Recommendation 21

7.75 The committee recommends the Australian Government fund a trial program that would provide assistance animals for veterans with Post Traumatic Stress Disorder (PTSD) stemming from their military service in order to gather research to support the eventual funding of animals for veterans with PTSD and/or other mental health conditions through the Department of Veterans' Affairs.

Assisting veterans and their families navigate services

7.76 The complex range of DVA and ESO services available for veterans, as well as those offered by federal, state and territory governments for the general population, was identified as a barrier to veterans accessing assistance. Veterans frequently reported lacking awareness of services or struggling to navigate the support services that were available to them. There is a need to develop a single website and information service that can operate to link veterans with local services and support, particularly ESOs.

7.77 Initially, information will need to be collected on available services, their eligibility and service area. This database or map of service can then be utilised to advise and direct veterans and their families to appropriate and available to them. This initiative will require ongoing maintenance to ensure it is relevant and up-to-date. It should also be public to facilitate coordination and cooperation by ESOs and community groups.

7.78 The committee considers that the Veterans and Veterans Families Counselling Service (VVCS) is the most appropriate organisation to take on this role. It is trusted in the defence community and received significant praise for the services it offered during the inquiry. The committee is also hopeful that linking information services with the primary counselling component of VVCS may assist to reduce stigma in taking the initial steps to seek assistance for veterans who may have mental health conditions.

Recommendation 22

7.79 The committee recommends that the Australian Government provide funding to support the Veterans and Veterans Families Counselling Service:

- **create and maintain a public database of services available to veterans; and**
- **provide an information service to assist veterans and families connect and access appropriate services provided by ex-service organisations and others.**

Advocacy and appeals

7.80 The committee has been disturbed by the accounts of veterans, advocates and lawyers in relation to the appeals process. On the evidence received, the committee is persuaded that an adversarial approach to appeals appears to have been taken by DVA and its lawyers in some cases. The committee is concerned that contracted lawyers representing DVA are not always acting in accordance with the Commonwealth's Model Litigant Guidelines. There are significant access to justice issues in relation to the DVA's capacity to use legal costs to deter appeals by veterans and other claimants. Structurally, the system for appeals through the VRB, AAT and Federal Court of Australia seems to be unfairly weighed against veterans seeking review of decisions. Access to legal aid to appeal decisions by veterans is limited.

7.81 Further, the committee has serious concerns regarding the sustainability of advocacy services to veterans. The volunteer advocacy system is under serious stress and is unlikely to be able to meet the needs of veterans into the future. There are also conflicting interests in DVA being responsible for the training of advocates who will then be charged with arguing against the decisions of DVA officers on behalf of veterans.

7.82 The committee recommends the establishment of a Bureau of Veterans' Advocates (BVA) institutionally modelled on the Bureau of Pensions Advocates in Canada. This would consist of a section of legally trained public servants with a mission to independently assist and advocate for veterans in making claims. The BVA will supplement and support the current system of volunteer advocates. Where necessary, the BVA will be allocated a budget to commission legal aid to assist veterans make appeals. The BVA will also take over responsibility for grants to ESOs regarding advocacy, training and accreditation of volunteer advocates and insurance issues.

7.83 This recommendation is not, in any way, to denigrate the work of the current cohort of volunteer advocates and those supported by ESOs. The committee was deeply impressed by many dedicated advocates committed to supporting veterans make their claims. Volunteer and ESO supported advocates will continue to be needed to assist the vast majority of veterans make claims. However, while legal representation should be avoided, any compensation system will be inherently adversarial in some circumstances. There should be a level playing field between DVA and veterans in relation to appeals. If DVA chooses to engage external legal representation to conduct an appeal, the BVA should be able to arrange and provide

appropriate legal representation on behalf of the relevant veteran. If veterans choose to use their own legal representation, that option will still be open to them.

Recommendation 23

7.84 The committee recommends that the Australian Government establish a Bureau of Veterans' Advocates to represent veterans, commission legal representation where required, train advocates for veterans and be responsible for advocate insurance issues.

Veterans' Review Board

7.85 In this context, the committee holds a concern regarding whether the established practice of excluding veterans' lawyers from the VRB is appropriate in all cases. A number of examples were provided where vulnerable veterans felt underrepresented or unable to fairly engage with VRB proceedings. The committee accepts that this practice has been maintained in order to allow the VRB to be an open and non-adversarial forum for veterans to seek review of decisions. The committee also acknowledges the genuine efforts that the VRB makes to support veterans in its proceedings.

7.86 However, given the long-term future of veterans is in the balance, and the structural barriers involved in making an appeal to the AAT, veterans should be able to achieve the fairest hearing possible. A universal prohibition on legal representation may not reflect the ranges of circumstances of veterans before the VRB, nor can it be described as 'veteran centric'. In the view of the committee, it is time that representation before the VRB is independently reviewed to assess if it still appropriate for all veterans. There may need to be additional supports put in place to ensure veterans are appropriately represented before the VRB or criteria may need to be developed to allow classes of vulnerable veterans to be legally represented. The Australian Law Reform Commission would be an appropriate body to conduct this review.

Recommendation 24

7.87 The committee recommends that the Australian Government establish an independent review of the representation of veterans before the Veterans' Review Board. This review should assess whether the rights of vulnerable veterans are being adequately protected and whether further support mechanisms for veterans appearing before the Veterans' Review Board are required.

Senator Alex Gallacher
Chair

Appendix 1

Submissions

1 Mr Peter Larter, Advocate, Australian Special Air Service Association

2 Mr Michael Bush

3 Name Withheld

4 Mr Craig Rohse

5 Confidential

6 Ms Sarah Perkins

7 Mr John Lawler

8 Mrs Catherine Lawler

9 Mr Michael Kucera

10 Name Withheld

10.1 Supplementary to submission 10

11 Name Withheld

12 Name Withheld

13 Mr Peter Hayes

14 Mr Gareth Jones

15 Name Withheld

16 Mr Daniel Foley

17 Mr William Forsbey, Gosford RSL Sub Branch

18 Name Withheld

19 Mr Kenneth Park

20 White Wreath Association Ltd

21 Mr Geoff Griffiths

22 Ms Lee Withers

23 Name Withheld

24 Confidential

25 Confidential

26 Mr Ashley Smith

27 Confidential

28 Mr Chris Johnston

29 Mr Michael Quinn

30 Mr Neville Bryant

31 Name Withheld

32 Repatriation Medical Authority

32.1 Supplementary to submission 32

33 Name Withheld

34 Name Withheld

35 Mr Richard Stone

36 Name Withheld

37 Mr Phillip Olsen

38 Mr Trent Bourne

39 Confidential

40 Ms Fiona Quinn

41 Mr Don Tate

41.1 Supplementary to submission 41

41.2 Supplementary to submission 41

41.3 Supplementary to submission 41

41.4 Supplementary to submission 41

42 Australian Psychological Society

43 Mr Lionel Clarke

43.1	Supplementary to submission 43
44	Dr Nick Ford
	Additional Information
45	Partners of Veterans Association of Australia
46	Name Withheld
47	Mr Lance McNamara
48	Mr Fulvio Voncina
49	Mr Mark Ericksson
50	Mr Harold Hurren
51	Mr R. Birt
52	Mr Paul Barker
53	Confidential
54	Mr David Kalman
55	Stuart .
56	Name Withheld
57	Mr Kane Barkham
58	Mr Gary Myors
59	Dr Steven Scally
60	Confidential
61	Name Withheld
62	Mr Nick Shelley
63	Confidential
64	Confidential
65	Mr Douglas McLauchlan
66	Mr Stephen Bloomer
67	Confidential

68 Name Withheld

69 Confidential

70 Confidential

71 Mr Graham Tredinnick

72 Mr Shane Van Duren

73 Name Withheld

74 Name Withheld

75 Name Withheld

76 Confidential

77 Name Withheld

78 Dr Jon Lane

79 Name Withheld

80 Mr Greg Grundy

81 Confidential

82 Name Withheld

83 Name Withheld

84 Mr William Sim

85 Name Withheld

86 Mr John Skewes

87 Mr Alan Ashmore

88 Mrs Renee Polkinghorne

89 Mr Darren Sapwell

90 Mr Shaun Fenech

91 Name Withheld

92 Name Withheld

93 Confidential

94 Mr Brad Kirkels

95 Confidential

96 Mr Michael Linnane

97 The William Kibby VC, Veterans' Shed

98 Confidential

99 Ms Tamara Rimland

100 Confidential

101 Mr A.R. Browning

101.1 Supplementary to submission 101

101.2 Supplementary to submission 101

101.3 Supplementary to submission 101

102 Mr Paul Bunker

103 Confidential

104 Ms Jessica Leonard

105 Mr John Stevens

106 Mr Mick Ryan

107 Mr Manning Townson

108 Mr Darryll Heedes

109 Mr Jack Fordyce

109.1 Supplementary to submission 109

110 Name Withheld

111 Name Withheld

112 Mr Brad Macdonald

113 Ms Tracie Cooke

114 Mr Adam Usher

115 Confidential

116 Mr Darren Barber and Mr Peter McNamara

117 Mr Russell Dally

118 Name Withheld

119 Mrs Miriam Bain

120 University of Canberra

121 Mr Damien Hick

122 Veterans' Review Board

123 Commonwealth Ombudsman

124 Department of Defence

124.1 Supplementary to submission 124

125 Confidential

126 Confidential

127 Administrative Appeals Tribunal

128 Dr Phoebe Donaldson

129 Mr Glen Coburn

130 Name Withheld

131 Confidential

132 Name Withheld

133 Ms Andrea Josephs

133.1 Supplementary to submission 133

134 Confidential

135 Confidential

136 Name Withheld

137 Name Withheld

138 Mr James Darby

139 Mr Peter Hawes

141 Name Withheld

142 Mr John Simmons

143 Confidential

144 Confidential

145 Name Withheld

146 Name Withheld

147 Mr John Mancey

148 Defence Force Welfare Association - Queensland Branch

148.1 Supplementary to submission 148

149 Name Withheld

150 Mr Richard Matthews

151 Confidential

152 Confidential

153 Confidential

154 Confidential

155 Dr Andrew Khoo

156 Department of Veterans' Affairs

156.1 Supplementary to submission 156

157 Dr Brian White

158 Confidential

159 Confidential

160 Slater & Gordon Lawyers

161 Legacy Australia

162 Veterans' Advisory Council South Australia

163 Royal Australian Regiment Corporation

164 Australian Families of the Military Research and Support Foundation

165 Royal Australian and New Zealand College of Psychiatrists

166 Private Mental Health Consumer Carer Network (Australia) Limited

167 Shine Lawyers

168 Inspector-General of the Australian Defence Force

169 RSL (Tasmania Branch) Inc.

170 Bravery Trust

Additional Information

170.1 Supplementary to submission 170

171 Dr Catriona Bruce and others

172 Alliance of Defence Service Organisations

172.1 Supplementary to submission 172

173 Mates4Mates

174 Australian Institute for Suicide Research and Prevention

175 Soldier On

176 Suicide Prevention Australia

177 Phoenix Australia - Centre for Posttraumatic Mental Health

178 Mr Andrew Travers

179 Mr David Treloar

180 Confidential

181 Name Withheld

182 Mr Nigel Brien

183 Ms Charmaine Binnie

184 Name Withheld

185 Mr Christopher Duffield

186 Mr Michael Crank

187 Government of South Australia

188 Mr Wayne Hopkinson

189 Mr John Burrows

189.1 Supplementary to submission 189

189.2 Supplementary to submission 189

190 Mr Kevin Conner

191 Mr John Tassell

192 Ms Crystal Peckett

193 Ms Bonny Perry

194 Confidential

195 Confidential

196 Mr Erik Wellington

197 Confidential

198 Mr Mirko Stojkov

199 Confidential

200 Mr Lex Reilly

201 Mr Ray Kemp

202 Australian Federal Police

203 Name Withheld

204 Confidential

205 Confidential

206 Mr Ray Blackburn

207 Mr David Griffiths

208 Mr Allan Anfort

208.1 Supplementary to submission 208

209 Name Withheld

210 Name Withheld

211 Mrs Jane Davis

212 Name Withheld

213 Mr David Stevenson

214 Mr Troy Dean

215 Mr John Nolan

216 Returned and Services League of Australia217 Confidential

218 Confidential

219 Confidential

220 Mr Ted Chitham

221 Name Withheld

222 Name Withheld

223 Adore Yoga

224 Mr John Kerr

225 Confidential

226 Confidential

227 Confidential

228 Name Withheld

229 Mrs Carly Fredrickson

230 Mr Gordon Smith

231 Ms Jacqui Bull

232 Mr Ian Sims

233 Name Withheld

234 Mr Samual Maraldo

235 Mr Damon Currie

236 Mr Ernest Morris

237 Name Withheld

238 Name Withheld

239 Confidential

240 Name Withheld

241 Mr Slade Kidner

242 Name Withheld

243 Confidential

244 Name Withheld

245 Mr Cameron McKnight

246 Name Withheld

247 Mrs Sarah Watson

248 Mrs Kylie Kidner

249 Confidential

250 Name Withheld

251 Name Withheld

252 Mr Shaun Young

253 Confidential

254 Name Withheld

255 Mr Walter Davis

256 Mr Daniel Kerton

257 Dr Frank Donovan

258 Name Withheld

258.1 Supplementary to submission 258

259 Name Withheld

260 Mr Peter Hayton

261 Vietnam Veterans Association of Australia - Northern Territory Rural Sub Branch

262 Confidential

263 Confidential

264 Mr Ben Johnson

265 Mr Mark Horner

265.1 Supplementary to submission 265

266 Mr Greville Knight

267 Mrs Penelope Looker

268 Name Withheld

269 Name Withheld

270 Name Withheld

271 Mr Joshua Weir

272 Brigadier Stephen Quinn (Retd), CSC

273 Mr Christopher Edmond

274 Mr Jim Duffield-Whyard

275 Diggers Rest @ Quailsridge.org

276 Ms Janet Kuys

277 Vietnam Veterans' Federation of Australia

277.1 Supplementary to submission 277

278 Victorian Government

279 Northern Suburbs Veterans Support Centre

280 Carers NSW

281 Victims of Abuse in the Australian Defence Force Association

282 Dr Kevin Kraushaar

283 Ray and Pam Palmer

284 Mr Alexander Kaczmarek

285 Weeded Warrior

286 Australian Suicide Prevention Foundation

287 NSW Government

288 Name Withheld

289 Confidential

290 Confidential

291 Name Withheld

292 Name Withheld

293 Mr Joe Turner

294 Mr Tom Jehn

295 Mr Arthur Ventham

296 Mr Jason Burgess

297 Mr Angus Sim

298 Confidential

299 Australian Association of Social Workers

300 Mr Gary Palmer

301 Confidential

302 Name Withheld

303 Name Withheld

304 Quinoline Veterans and Families Association

305 Mr Frank O'Neill

Additional Information

305.1 Supplementary to submission 305

306 Name Withheld

307 TPI Federation of Australia

308 Confidential

309 Confidential

310 Confidential

311 Confidential

312 Ms Kylie Nicholas

313 Mr Michael McMaster

314 Ms Michelle Roberts

315 Mr Adrian Ross

316 Mr Allen Morley

317 John and Karen Bird

317.1 Supplementary to submission 317

318 Donna .

319 Name Withheld

320 Mr Philip Clark

321 Dr Roderick Bain

321.1 Supplementary to submission 321

322 Corporal Chris Moore

323 Mr Max Ball

323.1 Supplementary to submission 323

323.2 Supplementary to submission 323

324 Mr Michael Wunderlich

325 Mr Mark Dwyer

326 Mr Michael Ryan

327 Dr James Alexander

328 Confidential

329 Name Withheld

330 Mrs Erin Ryan

331 Dr Robert Tym

332 Confidential

333 Confidential

334 Mr Rod Thompson

334.1 Supplementary to submission 334

335 Mr Peter Thornton

336 Name Withheld

337 Name Withheld

338 Ms Calli Morgan

339 Confidential

340 Ms Pauline Maczkowiack

341 Confidential

342 Dr. Van Davy

343 Mrs Veronica Conner

344 Mr Bradley Campbell

344.1 Supplementary to submission 344

344.2 Supplementary to submission 344

345 Confidential

346 Confidential

347 Confidential

348 Confidential

349 Confidential

350 Confidential

351 Confidential

352 Confidential

353 Confidential

354 Confidential

355 Confidential

355.1 Supplementary to submission 355

356 Confidential

357 Mr Geoffrey Shafran

357.1 Supplementary to submission 357

358 Confidential

359 Confidential

360 Confidential

361 Confidential

362 Confidential

363 Confidential

364 Confidential

365 Confidential

366 Name Withheld

367 Name Withheld

368 Confidential

369 Confidential

370 Ms Kelliegh Jackson

371 Name Withheld

372 Name Withheld

373 Ruff Love Assistance Dogs

374 Mr Timothy Chesterfield

375 Name Withheld

376 Name Withheld

376.1 Supplementary to submission 376

377 Mrs Carole Tate

378 Mr Peter Reece

378.1 Supplementary to submission 378

379 Hunter Institute of Mental Health

379.1 Supplementary to submission 379

380 Australian Men's Shed Association

381 Confidential

382 Mr Darryl Coventry

383 Mr Marcus Saltmarsh

384 Mr Philip Morris

385 Confidential

386 Name Withheld

387 Confidential

388 Mr Brendan Dwyer

389 Mr Terry Colless

390 Mr Terry Fogarty

391 Ms Karlie Cummins

392 Confidential

393 Mr Garry Ridge

394 Confidential

395 Ms Danielle Khan

396 Mr Paul Bremner

397 Ms Vic Shannon

398 Mr Garry Lisle

399 Mr Allan Thomas

400 Business Council of Co-operatives and Mutuals

401 Confidential

402	Australian National Veterans Arts Museum
403	Name Withheld
404	Dr Edward Scarr
405	Catholic Women's League of Australia
406	Mrs Catherine Stamp
407	Mr Richard Convery
408	Confidential
409	Confidential
410	Confidential
411	Confidential
412	Confidential
413	Confidential
414	Mr Peter Erdman
415	Confidential
416	Confidential
417	Confidential
418	Confidential
419	Confidential
420	Confidential
421	Confidential
422	Confidential
423	Confidential
424	Confidential
425	Confidential
426	Mr Graham Zalewska-Moon
427	One Door Mental Health

428 Mr Robert Bak

429 Confidential

430 Name Withheld

431 Mr Richard Chapman

432 Name Withheld

433 Ms Connie Boglis

434 Ms Vicki Cook

435 Name Withheld

436 Name Withheld

437 Name Withheld

438 Name Withheld

439 Mr Michael Hughes

440 Name Withheld

441 Ms Kate Bird

442 Ms Cassandra Biggs

443 Mr Kieran Toohey

444 Mr Daniel Liiv

445 Mr Brendan Bird

446 Name Withheld

447 Mr Keith Wells

448 Ms Lisha Taylor

449 Name Withheld

450 Name Withheld

451 Maurice Blackburn Lawyers

452 Mr Peter Easton

453 Royal Commission into DVA Working Group

454 Confidential

455 Name Withheld

456 Confidential

457 Mr David Passmore

458 Name Withheld

Appendix 2

Tabled documents, Answers to questions on notice and Correspondence

Tabled documents

1. Opening statement tabled by Returned and Services League of Australia (South Australian Branch), tabled at public hearing held on 17 November 2016

2. Opening statement tabled by South Australian Veterans' Advisory Council, tabled at public hearing held on 17 November 2016

3. Documents tabled by the Australian Institute for Suicide Research and Prevention, tabled at public hearing held on 2 February 2017

4. Opening statement tabled by Defence Force Welfare Association, Queensland Branch, tabled at public hearing held on 2 February 2017

5. Opening statement tabled by Slater and Gordon Lawyers, tabled at public hearing held on 2 February 2017

Answers to questions on notice

1. Mr Ray Kemp - response to question on notice from public hearing on 17 November 2016 (received 19 November 2016)

2. Mr Guy Bowering - response to question on notice from public hearing on 17 November 2016 (received 1 December 2016)

3. Private Mental Health Consumer Carer Network (Australia) - response to question on notice from public hearing on 2 February 2017 (received 15 February 2017)

4. Repatriation Medical Authority - response to question on notice from public hearing on 6 February 2017 (received 24 February 2017)

5. Administrative Appeals Tribunal - response to questions on notice from public hearing on 6 February 2017 (received 8 March 2017)

6. Department of Veterans' Affairs - responses to questions on notice from public hearing on 6 February 2017 (received 17 March 2017)

7. Department of Defence - response to question on notice from public hearing on 6 February 2017 (received 20 March 2017)

8. Department of Defence - responses to questions on notice from public hearing on 6 February 2017 (received 30 March 2017)

9. Department of Defence - responses to questions on notice from public hearing on 6 February 2017 (received 20 March 2017)

10. Department of Defence - responses to questions on notice from public hearing on 6 February 2017 (received 30 March 2017)

11. Department of Defence - responses to questions on notice from public hearing on 6 February 2017 (received 5 April 2017)

12. Department of Defence - responses to questions on notice from public hearing on 6 February 2017 (received 5 April 2017)

13. Department of Defence - responses to questions on notice from public hearing on 6 February 2017 (received 5 April 2017)

Correspondence

1. Letter received from Queensland Government, 10 November 2016

2. Letter received from Northern Territory Government, 24 November 2016

3. Letter received from Chief of Army, Lieutenant General Angus Campbell, DCS, AM, 12 December 2016

Appendix 3

Public hearings and witnesses

Thursday 17 November 2017

Dr Nick Forde, Senior Clinical Lecturer, Discipline of Psychiatry

Mr Ray Kemp – private capacity

Dr Jon Lane – private capacity

The William Kibby VC, Veterans' Shed

Mr Barry Heffernan, Shed Coordinator

Northern Suburbs Veterans Support Centre

Mr Arthur Ventham, Chair

Mr Guy Bowering – private capacity

Returned and Services League (South Australia Branch)

Ms Julia Langrehr, Chief Executive Officer

Brigadier Tim Hanna, State President

Mr Justin Brown, Director, Veterans Services

Government of South Australia

Mr Rob Manton, Director Veterans SA

Veterans' Advisory Council of South Australia

Air Vice Marshal Brent Espeland AM, Chair

Mr Chris Burns, SA Commissioner for Mental Health and member of the Veterans' Advisory Council SA

Ms Chantelle Graham, Member of the Veterans' Advisory Council, SA

Friday 18 November 2017

Soldier On

Mr John Bale, Chief Executive Officer

Ms Nicole Thomson-Pride, Communications and Media Manager

Partners of Veterans Association of Australia

Ms Narelle Bromhead, President

Mrs Lesley Minner, Entitlements Officer

Alliance of Defence Service Organisations

Colonel David Jamison AM (retd), National Spokesman, Royal Australian Armoured Corps Corporation

Mr Noel McLaughlin, Chairman

Suicide Prevention Australia

Mr Anastasios (Stan) Piperoglou, Director

Mr Ben Johnson – private capacity

Dr Catriona Bruce

Mr Sam Miller

Dr Julie Christie

Vietnam Veterans' Federation of Australia

Mr James Wain, National President

Mr Allan Anforth – private capacity

Trooper Evan Donaldson – private capacity

Thursday 2 February 2017

Australian Institute for Suicide Research and Prevention

Dr Katelyn Kerr, Clinical Psychologist

Dr Kairi Kolves, Principal Research Fellow and Course Convener

Dr Andrew Khoo, Director of Medical Services, Toowong Private Hospital

Defence Force Welfare Association - Queensland Branch

Mr John Lowis, President

Mr Robert Shortridge, Executive Vice President

Slater & Gordon Lawyers

Mr Brian Briggs, Practice Group Leader, Military Compensation

Private Mental Health Consumer Carer Network (Australia) Limited

Ms Janne McMahon OAM, Chair and Executive Officer

Mr Norm Wotherspoon, Coordinator for Queensland

Royal Australian and New Zealand College of Psychiatrists

Professor Malcolm Hopwood, President

Mates4Mates

Mr Simon Sauer, Chief Executive Officer

Ms Suzanne Desailly, General Manager Operations

Ruff Love Assistance Dogs

Mr Ricky Lawson, President

Mr Timothy Clark, Treasurer

Mr Russel Ward, Secretary

Phoenix Australia - Centre for Posttraumatic Mental Health

Professor David Forbes, Director

Dr Andrea Phelps, Deputy Director

Dr John Cooper, Consultant Psychiatrist

Monday 6 February 2017

Returned and Services League of Australia

Mr Robert Dick, Acting National President

Mr Jim Gilchrist, Deputy President

Veterans' Review Board

Mr Doug Humphreys, Principal Member

Ms Katrina Harry, National Registrar

Department of Defence

VADM, Ray Griggs AO, CSC, Vice Chief of the Defence Force

Mr David Morton, Director General Mental Health, Psychology and Rehabilitation

RADM Brett Wolski AM, Head People Capability

AVM Tracy Smart, Commander Joint Health

Administrative Appeals Tribunal

Ms Sian Leathem, Registrar

Mr Chris Matthies, Executive Director Strategy and Policy

Repatriation Medical Authority

Professor Nick Saunders AO, Chair

Professor Gerard Byrne, Member

Mr Paul Murdoch, Registrar

Dr Sandra Pollitt, Medical Researcher

Australian Peacekeeper and Peacemaker Veterans' Association

Mr Rod Thompson, Advocate Level 4

Mr Michael Quinn, Advocate Level 4

Department of Veterans' Affairs

Mr Simon Lewis PSM, Secretary

Ms Liz Cosson AM, CSC, Deputy Secretary

Mr Craig Orme DSC AM CSC, Deputy President, Repatriation Commission

Ms Carolyn Spiers, Principal Legal Adviser

Friday 5 May 2017

Mr Frank O'Neill – private capacity

Veterans Advisory Council Western Australia

Mr Max Ball, Chair

Mr Peter Larter, Advocate, Australian Special Air Service Association

Mr Peter Reece – private capacity

Australian Federation of Totally and Permanently Incapacitated (TPI) Ex-Service Men and Women

Ms Pat McCabe OAM, President

Mr Ray Pearce, WA Vice President

Bravery Trust

Mr Peter Fitzpatrick AM, Chair

Mr Sean Farrell, Chief Executive Officer